IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PATRICIA ACOSTA, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	CIVIL ACTION NUMBER. 1:04CV01618
	)	JUDGE: James Robertson
INTELSAT GLOBAL SERVICE CORP., et al.,	)	
	)	
	)	
Defendants.	)	

DEFENDANTS' MOTION TO DISMISS

Defendants Intelsat Global Service Corporation ("Intelsat Service"), Intelsat, Ltd., and Kathleen Alexander, Administrator, move to dismiss the Complaint in this action for failure to state a claim pursuant to Rules 12(b)(6) and 9(b) of the Federal Rules of Civil Procedure. The grounds for the Motion are set forth more fully in the accompanying Memorandum in Support of this Motion.

Respectfully submitted,

/s/ David R. Warner

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MEMORANDUM IN SUPPORT OF
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Defendants Intelsat Global Service Corporation ("Intelsat Service"), Intelsat, Ltd., and Kathleen Alexander, Administrator, submit this Memorandum in Support of their Motion to Dismiss for failure to state a claim pursuant to Rules 12(b)(6) and 9(b) of the Federal Rules of Civil Procedure.

INTRODUCTION AND OVERVIEW

Defendant Intelsat Service is a private corporation. It was created following the Congressionally-mandated privatization in July 2001 of the International Telecommunications Satellite Organization ("INTELSAT/IGO"), a public international organization established by its member governments to build and operate a global satellite communications network.[1] The privatization transaction concluded, and Intelsat Service began its operations, on July 18, 2001. Intelsat Service, as a private company, has adopted the Intelsat Group Health Plan,[2] an employee welfare benefit plan under which

[1] INTELSAT is an international governmental organization, or IGO; the IGO denomination is always used in this brief in connection with the name of the pre-privatization entity for purposes of clarity.
[2] The Intelsat Health Benefits Plan referred to in the Complaint does not exist. The correct name of the post-privatization health plan is "Intelsat Group Health Plan," and the plan administrator of this plan is

health care benefits are provided to certain retirees of INTELSAT/IGO or of Intelsat Service (the "Intelsat Plan"). The Intelsat Plan, which is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq. ("ERISA"), is set forth in a written summary plan description dated June 25, 2001 (the "June 2001 Summary Plan Description").[3]

This is the second lawsuit, both brought as class actions, challenging the provisions of the Intelsat Plan. The first lawsuit is docketed as Morales et al. v. Intelsat Global Service Corp. et al., Civil Action No. 1:04CV01044 ("Morales"), and Defendant Intelsat Service has filed a motion to dismiss in that case, which motion is currently in the briefing stage. The Complaint here and the Complaint in Morales both arise out of the same operative facts, and the two groups of named Plaintiffs purport to represent substantially the same or overlapping classes. Although the Acosta Complaint has been drafted in an attempt to circumvent the defects in the Morales Complaint, the object of both complaints is the same -- to impose on Intelsat Service as a private company certain commitments or obligations allegedly undertaken by INTELSAT/IGO prior to the privatization.

As noted above, Intelsat Service is currently providing health care benefits to retirees under the Intelsat Plan. Intelsat Service is the plan administrator of that Plan. There is no allegation in the Acosta Complaint (or in the Morales Complaint) that the Defendant plan administrator has not been paying benefits or otherwise administering the

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Intelsat Service. Defendants assume that Plaintiffs meant to name the plan administrator of this plan as a defendant.

[3] The June 2001 Summary Plan Description and the plan document for the Intelsat Plan are the same document, and, as used in this brief, the June 2001 Summary Plan Description also denotes the plan document. The June 2001 Summary Plan Description also incorporates certain other documents by reference.

Intelsat Plan in accordance with the written terms of the plan document, the June 2001 Summary Plan Description; indeed, that fact is at the core of Plaintiffs' dissatisfaction. Their claim is that the provisions of the Intelsat Plan -- the only ERISA plan providing medical benefits to the retirees at issue that has been adopted, sponsored, and administered by Intelsat Service -- do not reflect the benefits allegedly promised to them by INTELSAT/IGO before privatization.[4]

The fundamental legal hurdle confronting the Plaintiffs in both cases is that INTELSAT/IGO, as a public international organization, is, and always has been, immune from any attempt by its employees or retirees to enforce any obligation against it for health care benefits. The threshold legal issue presented by this case, as well as by the Morales case, is whether the act of privatization has somehow improved or enhanced the rights of the Plaintiffs, so that commitments allegedly made by INTELSAT/IGO, which, even if made, cannot be enforced against INTELSAT/IGO, may now be imposed by Plaintiffs on Intelsat Service as a private company. As discussed in the motion to dismiss filed in Morales and as elaborated on below, Intelsat Service submits that the answer to that question is a definitive "no." INTELSAT/IGO was not subject to ERISA, never sponsored an ERISA plan, and did not create any "vested" ERISA benefits enforceable against itself, much less "vested" benefits enforceable against Intelsat Service as a private company.

The Acosta Complaint has been brought by twenty-one named plaintiffs, all but five of whom retired before 1996, years before privatization of INTELSAT/IGO in 2001. Nonetheless, the Plaintiffs have not sued INTELSAT/IGO but, instead, have named as

[4] Plaintiffs claim that surviving spouses are entitled to more than the COBRA continuation coverage and conversion rights provided by the terms of the Intelsat Plan. Complaint ¶ 41. Plaintiffs also claim that the reservation of rights clause in the Intelsat Plan, id., is improper.

defendants Intelsat Service and Intelsat, Ltd., as well as the administrator of the Intelsat Plan.[5] INTELSAT/IGO is immune from suit. Accordingly, the Plaintiffs have sued the private Defendants, including Intelsat Service, which adopted the first and only ERISA plan at issue in this case, claiming that Intelsat Service is liable for benefits allegedly promised by non-Defendant INTELSAT/IGO.

Plaintiffs assert that INTELSAT/IGO, in a Resolution dated March 12, 2001 (the "March 2001 Resolution"), promised to maintain in perpetuity the health benefits for certain retired employees and their dependents at the level in effect as of January 1, 2001. Plaintiffs also assert that the March 2001 Resolution was extended to an additional group of individuals by a resolution of the Board of Governors of INTELSAT/IGO in April 2001 (the "April 2001 Resolution"; together, the "March and April 2001 Resolutions"). They claim that the March and April 2001 Resolutions by INTELSAT/IGO gave them vested welfare benefits under ERISA. In asserting this claim, Plaintiffs also refer to a series of statements allegedly made by INTELSAT/IGO. ¶¶ 29, 30, 32, 34, & 37. These statements, however, (a) were superseded by a merger and integration clause in the privatization Transfer and Restructuring Agreements; (b) were made by INTELSAT/IGO, an entity not subject to ERISA; and (c) were not contained in any ERISA plan document and did not suffice to create "vested rights." Indeed, only one of the statements on which Plaintiffs rely to impose liability on Intelsat Service, an October 2001 memorandum, was actually made by Intelsat Service, and that statement (a) was not contained in an ERISA

[5]The Complaint wholly fails to identify any acts, omissions, statements or other conduct of Intelsat, Ltd. or the Administrator of the Intelsat Plan that would subject them to liability. Consequently, those Defendants are entitled to dismissal of the Complaint against them on that ground, as well as for the reasons stated in this Memorandum.

plan document; (b) could not vary the terms of the Intelsat Plan; and (c) did not suffice to create "vested" ERISA rights.

Plaintiffs contend that Intelsat Service is liable as a successor to any resolutions or statements adopted by INTELSAT/IGO. Plaintiffs are wrong as a matter of law. Assuming *arguendo* that Intelsat Service is a "successor" to INTELSAT/IGO, under applicable New York law, a successor cannot assume a greater liability than that possessed by its predecessor, and any inherited liability also carries with it the "correlative benefit" of an immunity defense the predecessor could have asserted. For the same reasons, Intelsat Service, in its capacity as plan administrator or plan sponsor of the Intelsat Plan, cannot be liable for a breach of fiduciary duty based on the design and administration of a valid ERISA plan whose benefits seem inadequate to the Plaintiffs.

Plaintiffs' other claims are equally defective. Plaintiffs' claim for breach of contract fails as a matter of law. Their assertion of rights as third-party beneficiaries to the Restructuring and Transfer Agreements in connection with privatization is expressly precluded by those very documents and by the applicable New York law. No other contract is alleged. Furthermore, Plaintiffs' claim for estoppel on a class-wide basis fails because estoppel claims depend on the unique facts and circumstances relating to each individual Plaintiff. For example, sixteen of the named Plaintiffs retired years before the alleged "promises" on which the detrimental reliance element of the estoppel claim must be based. Plaintiffs have not even attempted to allege individual claims based on estoppel and detrimental reliance by any individual Plaintiff. Plaintiffs' claim for estoppel under ERISA fails for the additional reason that the doctrine does not apply in situations involving unambiguous plan terms, such as the terms of the Intelsat Plan. Finally, Count

IV of the Complaint fails to satisfy the pleading requirements of Rule 9(b) of the Federal Rules of Civil Procedure and warrants dismissal on that ground. Fed. R. Civ. P. 9(b).

STATEMENT OF FACTS

I. The Named Plaintiffs

The twenty-one named Plaintiffs allege that this action was filed on behalf of a class of "[a]ll persons covered by Pre-Privatization Intelsat's [INTELSAT/IGO's] March 2001 and April 2001 Board resolutions which vested certain health benefit rights in certain retirees, future retirees, their dependents and their surviving spouses." Complaint ¶ 45. Of the twenty-one named Plaintiffs, however, fully sixteen are persons who retired, or whose spouses retired, before the Board of Governors of INTELSAT/IGO adopted the March and April 2001 Resolutions, which allegedly "vested" the Plaintiffs' health benefits; indeed, all sixteen of these persons retired in or before 1995. See id. ¶¶ 1- 4, 6, 8, 11-13, 15-21.[6] In other words, sixteen of the twenty-one Plaintiffs retired, or are surviving spouses of persons who retired, at least six years before the alleged "vesting." Of the remaining five Plaintiffs, one retired between the dates of the INTELSAT/IGO March and April 2001 Resolutions and the privatization date of July 18, 2001. See id. ¶ 9 (Plaintiff Kristjansdottir, retirement date July 16, 2001). The other four retired on October 9, 1991, see id. ¶ 7 (Plaintiff Forcina), on March 1, 2002, see id. ¶ 10 (Plaintiff Krowitz), in June 2002, see id. ¶ 14 (Plaintiff Olson), and in May 2004, see id. ¶ 5 (Plaintiff Costello).

[6] These Plaintiffs retired in the following years: Acosta (spouse retired 1994); Aribe (1992), Brown (1994), Cammarata (1994), Fassano (1994), Koff (spouse retired 1994); Krueger (1994), Magee (1994), Magnusson (1995), Peters (1994), Rees (1991), Rowe (1989), Shannon (1994), van Reigersberg (1994), Williams (1994), and Westlake (1984).

II. INTELSAT/IGO

INTELSAT/IGO was established pursuant to a 1973 international treaty and in 1977 was designated as an international organization by Executive Order Number 11,966. 23 U.S.T. 3813; 42 Fed. Reg. 4331 (Jan. 19, 1977). As a result of this designation, INTELSAT/IGO enjoyed, and continues to enjoy, the comprehensive privileges and immunities provided in the International Organizations Immunities Act, 22 U.S.C. §§ 288 et seq. See 23 U.S.T. 3818 and 28 U.S.T. 2248. Thus, INTELSAT/IGO was not and is not subject to civil suit in the United States based on ERISA, contract law, or any other common or statutory law. See Complaint ¶ 22 (stating that the INTELSAT/IGO's health benefits program "was not covered by ERISA").

In March 2000, Congress mandated that INTELSAT/IGO privatize in order to promote a competitive global market for satellite communication services, see 47 U.S.C. §§ 761 et seq., and INTELSAT/IGO began taking the complex steps which culminated in its privatization in July 2001. A corporate structure was created which included Defendant Intelsat, Ltd., the second named defendant and an entity incorporated under the laws of Bermuda, and the entity that became (after a minor name change) the first named defendant, Intelsat Service, a Delaware corporation. As noted previously, upon privatization, Intelsat Service as plan sponsor adopted the Intelsat Plan and became the plan administrator.

III. The Privatization

The privatization was consummated on July 18, 2001, with the execution of two agreements relevant to plaintiffs' claims -- the Restructuring Agreement and the Transfer Agreement.

A. The Restructuring Agreement

The Restructuring Agreement (relevant excerpts attached as Ex. A)[7] provided that assets and liabilities of INTELSAT/IGO were to be transferred in accordance with the Transfer Agreement. It further provided in a merger and integration clause that "[t]his Agreement and the other Transaction Agreements . . . contain the entire agreement among the parties . . . and supersede all prior agreements and understandings, oral or written, with respect to such matters." Ex. A § 9.04.

The Restructuring Agreement also provided explicitly that no applicable third-party rights were created: "[N]othing in this Agreement or any other Transaction Agreement, express or implied, is intended to confer upon any Person other than the parties hereto . . . any rights or remedies under or by reason of this Agreement or any other Transaction Agreement." Ex. A § 9.05.

The Restructuring Agreement is governed by New York law. Ex. A § 9.06.

B. The Transfer Agreement

The Transfer Agreement (excerpt attached as Ex. B) provided that all assets and liabilities of INTELSAT/IGO (except those specifically excluded) were transferred to Intelsat, Ltd. Ex. B §§ 2.01 and 2.03. Like the Restructuring Agreement, the Transfer Agreement contained a merger and integration clause (Ex. B § 11.04), and a clause expressly stating that no applicable third-party rights were created (Ex. B § 11.05 (a)). This Agreement is also governed by New York law. Ex. B § 11.06.

[7] Due to the length and confidentiality of some of the schedules and exhibits, the Restructuring Agreement and the Transfer Agreement are not attached in their entireties. If they are requested, these documents will be provided in their entirety following the entry of a suitable protective order.

IV. The March and April 2001 INTELSAT/IGO Resolutions

Prior to privatization, the Board of Governors of INTELSAT/IGO adopted the March 2001 Resolution (copy attached as Ex. C), which addressed the issue of retired employee medical benefits after privatization. See Complaint ¶ 35. The March 2001 Resolution purported to assure that Intelsat Service would continue the January 1, 2001 level of medical benefits for certain retirees after privatization, that the terms of the March 2001 Resolution would be incorporated into the privatization documents, and that the benefits would be described in a summary of plan benefits. A separate INTELSAT/IGO Resolution adopted in April 2001 by the Board of Governors extended the coverage of the March 2001 Resolution to "additional classes of staff." Complaint ¶ 36.

V. The June 2001 Summary Plan Description

As of date of the privatization, the June 2001 Summary Plan Description (copy attached as Ex. D) described the medical benefits available to retired employees under the Intelsat Plan, effective as of January 1, 2001. This document was adopted as the ERISA summary plan description and plan document for the Intelsat Plan. It specifically includes language that provides that coverage for the surviving spouse of a deceased retiree terminates with the death of the retiree, but permits the surviving spouse to elect COBRA coverage for a period of time and provides for conversion rights thereafter. Ex. D. §§ 3.2(f), 3.6, and 4.1 et seq. In addition, the June 2001 Summary Plan Description specifically reserves to Intelsat Service, the plan sponsor, the option of altering the benefits in the future (i.e., a reservation of rights). Complaint ¶ 41. As of the filing dates in both Morales and Acosta, Intelsat Service had not exercised this reserved right to reduce benefits provided under the Intelsat Plan.

VI. Other Alleged Statements Relating to Retiree Health Benefits

In addition to INTELSAT/IGO's March and April 2001 Resolutions, Plaintiffs refer to various other statements that allegedly relate to health benefits. As discussed *infra*, none of these statements was contained in an ERISA "plan document," and there is no allegation that any of these statements was made in, or constitutes, an ERISA "plan document":

1. A November 1993 description of surviving spouse benefits (¶ 29);
2. A November 1994 notice of an Early Voluntary Retirement Program ("1994 EVR")(¶ 30);
3. A 1998 booklet describing the 1994 EVR (id.);
4. A 1997 description of benefits that INTELSAT/IGO extended to retirees (¶ 32);
5. An October 2000 statement by the Director General and CEO of INTELSAT/IGO that the "current health benefits would not be modified prior to privatization" and that INTELSAT/IGO management had "no present intent to initiate any reduction in benefits" (¶ 34)(emphasis added);
6. A May 2001 statement by the Director General and CEO of INTELSAT/IGO that the March 2001 Resolution guaranteed the level of benefits (¶ 37); and
7. An October 9, 2001 statement made in connection with a "voluntary separation program" that was made to "some retirees" describing purportedly vested health benefits (¶ 39).

Items 1 to 6 above, all of which are attributed to INTELSAT/IGO, will be referred to hereinafter as the "Statements." Item 7, the only one alleged to have been made after the

privatization date and the only one attributed to Intelsat Service, will be referred to hereinafter as the "October Statement."

ARGUMENT

I. Standards Applicable to Motion to Dismiss

A. Rule 12(b)(6)

A motion pursuant to Rule 12 (b)(6) should be granted where the allegations of the complaint fail to state a claim upon which relief can be granted as a matter of law. James V. Hurson Assocs., Inc. v. Glickman, 229 F.3d 277 (D.C. Cir. 2000) (affirming dismissal of that part of complaint alleging violation of rule making procedures because the procedures had not been violated, as a matter of law); Bristol-Myers Squibb Co. v. Shalala, 91 F.3d 1493 (D.C. Cir. 1996) (affirming dismissal of complaint because, as a matter of law, plaintiff asserted an erroneous interpretation of federal law and regulations); Confederate Mem. Ass'n, Inc. v. Hines, 995 F.2d 295 (D.C. Cir. 1993) (complaint failed to allege elements of claims under the applicable law); Committee of U.S. Citizens Living in Nicar. v. Reagan, 859 F.2d 929 (D.C. Cir. 1988) (claims fail as a matter of law in that they are not enforceable in a domestic court or by private citizens).

B. Submission by Defendants of Documents Referred to in Complaint Is Proper in Connection with a Motion to Dismiss.

Plaintiffs refer to a number of documents in their Complaint but do not attach copies. Defendants thus attach copies of the following documents, all referred to in the Complaint:

Ex. A: Excerpt from the Restructuring Agreement;

Ex. B: Excerpt from the Transfer Agreement;

Ex. C: March 2001 Resolution; and

Ex. D: June 2001 Summary Plan Description

It is well-established that documents referred to in a complaint that are central to the plaintiffs' case but not attached as exhibits to the complaint may be provided by the defendants with a motion to dismiss without converting the motion to a motion for summary judgment:

> when the plaintiff fails to introduce a pertinent document as part of her pleading, a significant number of cases from throughout the federal court system make it clear that the defendant may introduce the document as an exhibit to a motion attacking the sufficiency of the pleading; that certainly will be true if the plaintiff has referred to the item in the complaint and it is central to the affirmative case.

5 CHARLES ALAN WRIGHT AND ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 1327 (3d. ed. 2004); Krooth & Altman v. North Am. Life Assurance Co., 134 F. Supp. 2d 96, 99 (D.D.C. 2001); Venture Assocs. v. Zenith Data Systems, 987 F.2d 429, 431 (7th Cir. 1993); Pension Benefit Guar. Corp. v. White Consolidated Indus., Inc., 998 F.2d 1192, 1196 (3d Cir. 1993).

II. Count I Does Not State a Claim for Violation of an ERISA Plan.

There is one, and only one, ERISA plan at issue in this case: the Intelsat Plan, which is governed by ERISA, sponsored and administered by Intelsat Service, and described in the June 2001 Summary Plan Description. In an effort to deflect attention from, and to avoid the application of, the terms of this ERISA plan, which governs their health benefits upon retirement, Plaintiffs rely on the series of documents and statements that constitute the Statements and the October Statement. Neither the Statements nor the October Statement satisfy the stringent requirements for a plan document under ERISA and, therefore, do not create ERISA rights on which Plaintiffs may rely. Apart from the

fact that the Statements and the October Statement do not qualify as ERISA plan documents, only the October Statement may be attributed to Intelsat Service. The others all precede the July 18, 2001 privatization date. Under New York law on successor liability, Intelsat Service could not have assumed greater liability than its alleged predecessor had. Moreover, under New York law, assuming *arguendo* that Intelsat Service may have succeeded to any claims for health benefits that Plaintiffs may have had against INTELSAT/IGO, the "correlative benefit" of the comprehensive immunity defenses that INTELSAT/IGO could have asserted to any such claims also attaches to the inherited claims. If the claim for a violation of vested ERISA rights in Count I had been brought against INTELSAT/IGO, it would have failed as a matter of law based on INTELSAT/IGO's immunity. Under New York law, Intelsat Service has *exactly the same immunity* from this claim that it allegedly assumed from INTELSAT/IGO.

A. The June 2001 Summary Plan Description is the Only ERISA Plan Document Referred to in the Complaint.

At privatization, Intelsat Service adopted the Intelsat Plan — an ERISA plan applicable to its employees and retirees. The June 2001 Summary Plan Description, which describes the terms and conditions of the ERISA plan, is in fact the only actual ERISA plan document referred to in the Complaint. A copy is submitted by defendants as Ex. D. This ERISA plan document:

- Contains a reservation of rights, permitting the plan sponsor (Intelsat Service) to alter or amend benefits in the future;
- Provides that a spouse's coverage terminates with the death of a retiree, but permits surviving spouses of retirees to elect COBRA coverage for a period of time and provides conversion rights thereafter; and

- Does not create "vested" welfare benefits in favor of Plaintiffs.

Ex. D at 5, §§ 3.2(f), 3.6, & 4.1 et seq.

These provisions are valid and binding under ERISA. The adoption of a welfare plan with language reserving to the plan sponsor the unqualified right to amend, modify, or terminate any of the terms, provisions, or benefits of the plan — or indeed the plan as a whole — is entirely proper. Sprague v. General Motors Corp., 133 F.3d 388, 400 (6th Cir. 1998); Wise v. El Paso Natural Gas Co., 986 F.2d 929, 934 (5th Cir. 1993); In re Unisys Corp. Retiree Med. Benefit ERISA Litig., 58 F.3d 896, 903 (3d Cir. 1995); Gable v. Sweetheart Cup Co., Inc., 35 F.3d 851, 856 (4th Cir. 1994). Thus, the adoption of these provisions in the June 2001 Summary Plan Description by Intelsat Service in connection with privatization was fully permissible and is not actionable under ERISA. The Plaintiffs do not allege that Intelsat Service is deviating from the terms of this valid ERISA plan; the gravamen of the Complaint is that they do not like the valid ERISA plan that Intelsat Service is administering faithfully and fairly.

B. Neither the Statements Nor the October Statement Create ERISA Rights.

In the face of the language of the only ERISA plan providing medical benefits that applies to the Plaintiffs, the Complaint attempts to fashion ERISA rights merely by reciting the Statements and the October Statement, each of which has no binding effect in itself. All of these, except the October Statement, were statements made by INTELSAT/IGO, an entity not subject to ERISA, and therefore did not create ERISA rights. Neither the Statements nor the October Statement was made in an ERISA plan document. And, to the extent that the Plaintiffs rely on principles of successor liability,

those principles do not support the claim that Intelsat Service is liable as a successor to ERISA claims.

1. *INTELSAT/IGO Was Immune from Civil Claims and Not Subject to ERISA; Its Statements, Therefore, Did Not Create ERISA Rights.*

INTELSAT/IGO was not subject to ERISA or any other law. As noted above, INTELSAT/IGO was established pursuant to a 1973 international treaty and in 1977 was designated as an "international organization" by Executive Order Number 11,966. 23 U.S.T. 3813; 42 Fed. Reg. 4331 (Jan. 19, 1977). International organizations, including INTELSAT/IGO, have broad immunity similar to the immunity of a foreign government: See International Organizations Immunities Act, 22 U.S.C. § 288a (b)("International organizations . . . shall enjoy the same immunity from suit and every form of judicial process as is enjoyed by foreign governments" except when the immunity has been waived "for the purpose of any proceedings or by the terms of any contract."). Judicial decisions make clear that the immunity under the International Organizations Immunities Act applies to internal employment matters. See Broadbent v. Organization of American States, 628 F.2d 27, 35 (D.C. Cir. 1980)("[T]he relationship of an international organization with its internal administrative staff is noncommercial, and, absent waiver, activities defining or arising out of that relationship may not be the basis of an action against the organization regardless of whether international organizations enjoy absolute or restrictive immunity."); see also Weidner v. International Telecomm. Satellite Org., 392 A.2d 508 (D.C. 1978) (breach of employment contract claim dismissed because INTELSAT/IGO was immune from suit under the International Organizations Immunities Act).

This Court, in Chiriboga v. International Bank for Reconstruction and Development, 616 F. Supp. 963 (D.D.C. 1985), held that "an international organization is entitled to such privileges and such immunity . . . as are necessary for the fulfillment of the purposes of the organization" and noted the D.C. Circuit "has repeatedly upheld the immunity of various international organizations from suits arising out of an employment relationship. " Id. at 966 (citations omitted). This immunity has been expressly extended to issues about employee benefits, which were part of the employment relationship as to which the immunity of the International Organizations Immunities Act extended: "The heart of the plaintiffs' claim is that the Bank denied plaintiffs employee benefits to which they were entitled as named beneficiaries and the personal representative of a deceased employee and her spouse. . . . It is difficult to imagine a suit that touches more closely on the internal operations of an international organization." Id. at 967; see also De Luca v. United Nations Org., 841 F. Supp. 531, 534 (S.D.N.Y. 1994) (claim for COBRA continuation coverage under a medical plan sponsored by the United Nations dismissed on immunity grounds); Shamsee v. United Nations, 74 A.D.2d 357, 361 (N.Y. App. Div. 1980) (administrator of pension fund sponsored by the United Nations is an organ of the United Nations and entitled to immunity under the International Organizations Immunities Act).

Under the law discussed above, INTELSAT/IGO would have been (and is) immune from claims based on any alleged obligations to provide employee benefits. As a matter of law, INTELSAT/IGO cannot impose any greater obligation on Intelsat Service as a private company than INTELSAT/IGO itself had as an obligation. In addition, the privatization documents themselves definitively bar any claim that the March and April

2001 Resolutions did, in fact, impose any greater obligations on Intelsat Service. As described above, both the Restructuring Agreement and the Transfer Agreement contain merger and integration clauses which state that the agreements "contain the entire agreement among the parties and supersede all prior agreements and understandings, oral or written, with respect to such matters." Ex. A § 9.04; Ex. B § 11.04. The Resolutions have not been incorporated into the privatization documents. Thus, any promise that is not contained in the Restructuring and Transfer Agreements — such as the March and April 2001 Resolutions — was vitiated by those documents and is not binding on any one.

2. *None of the Statements Plaintiffs Rely On Constitute "Plan Documents."*

Independent of the fact that all the Statements except the October Statement are attributable only to INTELSAT/IGO, none of them—including the October Statement—constitutes an ERISA "plan document" that creates "vested" rights to health benefits. In order for a promise to vest retiree health benefits that are enforceable under ERISA, the intent to vest those benefits must be found in clear and express language in plan documents. Sprague, 133 F.3d at 400; Wise, 986 F.2d at 937; In re Unisys Corp., 58 F.3d at 901; Gable, 35 F.3d at 855.

Only documents that meet the requirements of Section 402(b) of ERISA are considered "plan documents" for purposes of examining whether there is clear and express language vesting retiree health benefits. Sprague, 133 F.3d at 403; Gable, 35 F.3d at 857 n.2. Section 402(b) of ERISA requires four detailed provisions that must be met by every plan document. A plan document must:

> (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

> (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title [allocation and delegation of fiduciary duties),
>
> (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and
>
> (4) specify the basis on which payments are made to and from the plan.

29 U.S.C. § 1102(b). None of the Statements is alleged to have satisfied these requirements, and on the face of the allegations, the Statements plainly do not satisfy the test to be considered ERISA "plan documents." Likewise, the October Statement provided to "some plaintiffs" is not an ERISA "plan document" because it did not, among other things, provide a procedure for allocating responsibilities for the operation and administration of the plan, and it did not provide a procedure for amending the plan or identify the persons who have authority to amend the plan.

3. *None of the Statements Suffices to Establish "Vested" ERISA Rights.*

In addition to the fact that neither the Statements nor the October Statement is an ERISA "plan document," none contains the necessary language to establish a "vested" right under ERISA. The Seventh Circuit summarized the applicable ERISA law in Vallone v. CNA Financial Corp., 375 F.3d 623 (7th Cir. 2003):

> We start from the premise that "[e]mployers . . . are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." Curtis-Wright Corp. v. Schoonejongen, 514 U.S. 73, 115 S. Ct. 1223, 131 L.Ed.2d 94 (1995). For this reason, if ERISA welfare benefits "vest at all, they do so under the terms of a particular contract." Pabst Brewing Co. v. Corrao, 161 F.3d 434, 439 (7th Cir. 1998). The Supreme Court, followed by several courts of appeals, has indicated that a modification that purports to vest welfare benefits must be contained in the plan document and must be stated in clear and express language. See Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510, 515, 117 S.Ct. 1513, 137 L.Ed.2d 763(1997); Frahm v. Equitable Life Assurance Soc'y, 137 F.3d 955, 958 (7th Cir. 1998)(citing Sprague v. General

Motors, 133 F.3d 388, 400(6th Cir. 1998)(en banc) as sensibly extending the requirement of a writing to all long-term commitments; Gable v. Sweetheart Cup Co., Inc., 35 F.3d 851, 855-56 (4th Cir. 1994); Wise v. El Paso Natural Gas Co., 986 F.2d 929, 937 (5th Cir.1993).

The Statements are alleged to contain language such as "may continue," "eligible to continue," and "will be continued," but are not alleged to include any language guaranteeing benefits for any particular period of time or guaranteeing that benefits would not change. Complaint ¶¶ 29, 30.[8] In contrast, the plain language of the June 2001 Summary Plan Description reserves to Intelsat Service the unfettered right to amend or change any of the terms of the Intelsat Plan. In light of this clear and unambiguous language of the June 2001 Summary Plan Description, the content of the Statements and the October Statement, made in documents that do not satisfy the legal standards for being considered ERISA "plan documents," cannot suffice to create "vested" rights that are enforceable under ERISA.

C. Intelsat Service is Not Liable under Principles of Successor Liability for Any Greater Liability than INTELSAT/IGO Arguably Had, and INTELSAT/IGO's Immunity Attaches to Any Claims Asserted Against Intelsat Service as Successor.

It in unclear whether Plaintiffs' claim for a violation of ERISA is based, in whole or in part, on the principles of successor liability to which the Complaint alludes elsewhere. See Complaint ¶¶ 53-54 (setting forth allegations of Count I for Violation of ERISA without referring to successor liability). But see ¶ 52 (boilerplate incorporation of

[8] This language also undermines any contention that the Statements are "plan documents" because this language leaves open issues about the duration of the benefits. Even statements that provide more specific time frames or appear to guarantee that benefits would not change for particular periods have been held not to create enforceable rights under ERISA. Vallone, 375 F.3d at 628 (statements regarding "lifetime" retiree health benefits were not enforceable promises); Sprague, 133 F.3d at 401 (statements that health coverage would be paid at no cost for retirees "lifetimes" were not enforceable promises). *A fortiori*, statements without such language cannot give rise to enforceable rights under ERISA.

prior allegations). To the extent that the ERISA claim is based on successor liability, the claim fails as a matter of law.[9]

Assuming *arguendo* that Intelsat Service has succeeded to the liabilities of INTELSAT/IGO, Intelsat Service has *not* succeeded to any liability under ERISA.[10] As established above, INTELSAT/IGO did not create any enforceable ERISA rights. Where successor liability applies at all, "a successor corporation [that] assumed the liabilities [of a predecessor] ***could assume no more liability*** than" the predecessor had. Kubiszyn v. Terex Division of Terex Corp., 628 N.Y.S.2d 994, 997 (1995)(emphasis added). As the Terex court held, "[w]e perceive no sound reason to impose greater liability upon a successor corporation than that possessed by its predecessors . . . ." Id. The Plaintiffs' attempt to graft ERISA liability onto any obligations that Intelsat Service may have assumed from INTELSAT/IGO is little more than an attempt to impose greater liability on Intelsat Service than INTELSAT/IGO had. New York law clearly forecloses any such argument.[11]

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[9] If the ERISA claim is not based on successor liability, it fails as a matter of law because the only ERISA plan adopted by Intelsat Service providing medical benefits to the retirees at issue is the Intelsat Plan, and that Plan has been administered in accordance with its terms as required by ERISA.

[10] The Complaint fails to properly allege that Intelsat Service is liable as a successor to INTELSAT/IGO. Under New York law, which applies to the Transfer and Restructuring Agreements, "[t]he general common-law rule is that a corporation that merely purchases the assets of another corporation is not liable for the seller's debts and liabilities." Cargo Partner AG v. Albatrans Inc., 207 F. Supp. 2d 86, 93 (S.D.N.Y. 2002)(citing Schumacher v. Richards Shear Co., 59 N.Y.2d 239, 244-45, 464 N.Y.S.2d 437, 440, 451 N.E.2d 195 (1983), aff'd, 352 F.3d 41 (2nd Cir. 2003)). This well-established rule is qualified by four exceptions: purchaser is liable for the obligations of the seller if (1) the purchaser expressly or impliedly agrees to assume such obligations, or (2) there was a consolidation or merger of the seller and the purchaser, or (3) the purchaser is a mere continuation of the seller, or (4) the transaction is entered into fraudulently in order to escape liability for such obligations. Schumacher, 59 N.Y.2d at 245, 464 N.Y.S.2d at 440, 451 N.E.2d 195. See also 15 Fletcher Cyclopedia of Private Corp. § 7122. Because it is clear that there can be no successor liability for the rights claimed in this case, Defendants will assume *for purposes of this argument only* that Intelsat Service may be a successor under one of these exceptions.

[11] Issues of successor liability are controlled by the Transfer and Restructuring Agreements, which contain a choice-of-law provision selecting New York law. See Wheat, First Securities, Inc. v. Green. 993 F.2d 814, 821 (11th Cir. 1993)(contractual choice-of-law provisions in asset purchase agreement determines which forum's laws will apply to issues of successor liability); Berg Chilling Systems, Inc. v. Hull Corp., 2002 WL 31681955, *5 (E.D.Pa. 2002)(where asset purchase agreement contains a "broadly-worded choice of law

Although by statute Intelsat Service does not enjoy the full immunity for its own acts that applied to INTELSAT/IGO, INTELSAT/IGO's immunity attaches to any claim that Intelsat Service may have inherited from INTELSAT/IGO. A successor corporation that assumes a liability of its predecessor is "entitled to inherit the correlative benefit of any immunity from suit or liability held by" the predecessor. Id. To the extent that the Plaintiffs assert liability that Intelsat Service allegedly assumed from INTELSAT/IGO, that liability retains the "correlative benefit" of the immunity that attached to any liability that INTELSAT/IGO passed to Intelsat Service. There is no question, and Plaintiffs do not dispute, that INTELSAT/IGO had absolute immunity from the very claims that Plaintiffs assert here. Under New York law, that immunity defense cannot be decoupled from the claim when the same claim is asserted under principles of successor liability. Because INTELSAT/IGO was immune from any claim under ERISA or other law, Intelsat Service would have the benefit of that immunity if successor liability applies at all. Accordingly, any claim based on successor liability must fail as matter of law.

D. Plaintiffs Have Not Stated a Claim for Breach of Fiduciary Duty Under ERISA.

Plaintiffs are also incorrect in alleging that the "unilateral changes in the benefits under the vested Plan constitutes [sic] . . . a breach of fiduciary duty." Complaint ¶ 53.

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provision," the contractual choice of law applies to issues of successor liability). The District of Columbia courts honor such contractual choice-of-law provisions. Milanovich v. Costa Crociere, 954 F.2d 763, 767 (D.C.Cir.1992)(noting that under American law, choice of law provisions are usually honored); Restatement (Second) of Conflict of Laws § 187 (1971). In any event, New York law reflects generally accepted principles of successor liability. See 19 Am Jur.2d Corporations § 2724 (2002)(liability of successor "cannot be more burdensome" than that possessed by predecessor). Cf. Restatement (Second) of Contracts § 334 cmt. (1981) ("[A] right cannot be assigned if the effect would be to change materially the duty of the obligor.").

Underlying this claim is the assumption that Intelsat Service is bound by the promises allegedly made by INTELSAT/IGO and does not have the benefit of INTELSAT/IGO's immunity. If, as discussed above, Intelsat Service is not bound and does have the immunity as an alleged successor to INTELSAT/IGO, then there has been no actionable change to Plaintiffs' benefits, and Plaintiffs have no claim for breach of any fiduciary duty. Apart from the conclusory insertion of the phrase "breach of fiduciary duty" in the second sentence of Paragraph 53, the Complaint alleges no facts in support of this claim. The breach of fiduciary duty claim, as alleged, apparently is based on the same facts alleged in support of claim for "breach of plaintiffs' rights under the plan." Id. Accordingly, the breach of fiduciary duty claim is based on the design, creation, and adoption of the Intelsat Plan by Intelsat Service.

This claim also fails as a matter of law. It is well-established that creating or adopting an ERISA plan is not itself a fiduciary act, and that no claim for breach of fiduciary duty can arise from these actions. Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 444 (1999) (plan sponsors are generally free under ERISA to design, adopt, modify, or terminate welfare plans; plan sponsors undertaking such actions are not acting as fiduciaries); Lockheed Corp. v. Spink, 517 U.S. 882, 890 (1996) (same); Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995) (same); Systems Council EM-3 v. AT&T Corp., 159 F.2d 1376, 1379 (D.C. Cir. 1998) (same). Furthermore, when designing a welfare plan, no law requires an employer to provide health care coverage for retirees or their spouses, nor does any law require an employer to vest welfare benefits, such as retiree health benefits. Spink, 517 U.S. at 886; Curtiss-Wright, 514 U.S. at 78; Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983). Defendants have no obligation to provide

the benefits claimed by Plaintiffs, and Plaintiffs cannot state a claim for "failure to design" the plan that they wish that Intelsat Service had adopted. Plaintiffs do not claim that Intelsat Service is not following its own ERISA plan. Indeed, Plaintiffs claim that Intelsat Service is following an ERISA plan, to which Plaintiffs object. ¶¶ 42-44. Administering an ERISA plan in accordance with its written terms is precisely the fiduciary obligation of a plan administrator under ERISA Section 404(a)(1)(D). Consequently, no claim of breach of fiduciary duty is thus stated by Plaintiffs, as a matter of law.

III. Count II Does Not State a Claim for Breach of Contract.

Viewed in the light most favorable to Plaintiffs, it appears that Plaintiffs are attempting to allege in Count II two separate theories of contract liability, both of which fail as a matter of law. First, Plaintiffs allege that Intelsat Service breached its contract with INTELSAT/IGO, as to which Plaintiffs were allegedly third-party beneficiaries. See ¶¶ 56 & 57. Second, Plaintiffs appear to allege that Intelsat Service breached the terms of a contract between Intelsat Service and Plaintiffs. The third-party beneficiary theory is expressly foreclosed by the contracts at issue — the Restructuring Agreement and the Transfer Agreement — and applicable New York law. The bilateral contract theory is devoid of any factual allegations whatsoever that identify any contract between the Plaintiffs and Intelsat Service, or that support an offer, acceptance, and consideration for such any such bilateral contract.

A. The Plaintiffs Have No Claim as Third-Party Beneficiaries.

The Restructuring Agreement and the Transfer Agreement expressly provide that no applicable third-party rights are created. Ex. A §§ 9.03, 9.05; Ex. B § 11.05(a). These provisions are valid and enforceable under New York law, and fully bar Plaintiffs' third-

party beneficiary claim as a matter of law. The intention to create rights enforceable by third parties as third-party beneficiaries of the contract must be clearly expressed in the contract itself. Onanuga v. Pfizer, Inc., 2003 WL 22670842 *5, No. 03 Civ. 5404 (CM) (S.D.N.Y. Nov. 7, 2003). An express provision in the contract barring third-party rights is determinative and enforceable. Fitzpatrick v. County of Suffolk, 138 A.D.2d 446, 449 (N.Y. App. Div. 1988) (enforcing two contracts with clauses providing that there were no third-party rights); Nepco Forged Prod., Inc. v. Consolidated Edison Co., 99 A.D.2d 508 (N.Y. App. Div. 1984) (enforcing a provision in an agreement expressly negating an intent to permit enforcement by third parties). See also 22 N.Y. Jur. 2d Contracts § 302.

The provisions of the Restructuring Agreement and the Transfer Agreement that expressly disclaim third-party rights preclude the third-party beneficiary claim under New York law. These provisions, which expressly negate any claim to third-party rights, are enforceable under New York law. Moreover, the Plaintiffs have not alleged, and could not allege in light of the express language of the agreements *disclaiming* third-party rights, that the agreements "clearly expressed" an intent to *create* such rights.

B. Plaintiffs Have Not Alleged A Bilateral Contract Between Them and Intelsat Service.

If, in fact, the Plaintiffs are attempting to allege that Intelsat Service breached a contract to which the Plaintiffs were, themselves, a party, such a claim has no merit. The Complaint identifies no such contract, and there are no factual allegations from which any such contract could be inferred. Moreover, there are no allegations to support the requisites for the formation of a contract, i.e., offer, acceptance, and consideration, between the Plaintiffs and Intelsat Service. See Virtual Defense and Development Intern.,

Inc. v. Republic of Moldova, 133 F. Supp.2d 9 (D.D.C. 2001). In short, Count II fails to state a claim for breach of contract and should be dismissed.

IV. Count III Does Not State a Claim for Estoppel.

In Count III, Plaintiffs seek class-wide relief on the basis of estoppel. Here, the facts allegedly supporting estoppel vary significantly with each individual plaintiff. There are no individual allegations relating to any of the named Plaintiffs; there are no allegations as to what statements or promises were supposedly made to each individual plaintiff; there are no allegations about any reliance, whether reasonable or not, by an individual plaintiff; and there are no allegations about how any individual plaintiff acted to his or her detriment based on any statement or promise allegedly made to that individual plaintiff. Yet all of these allegations are required to make out a claim for estoppel. Sprague, 133 F.3d at 398 ("An estoppel claim requires proof of what statements were made to a particular person, how the person interpreted those statements, and whether the person justifiably relied on the statements to his detriment."). Indeed, in light of the highly individualized nature of an estoppel claim, the courts have concluded that estoppel claims are generally not susceptible to class-wide relief. As the court in Sprague explained, in language that applies directly to this case:

> Plaintiffs' estoppel theory was even less susceptible to class-wide treatment. An estoppel claim requires proof of what statements were made to a particular person, how the person interpreted those statements, and whether the person justifiably relied on the statements to his detriment. . . . Because of their focus on individualized proof, estoppel claims are typically inappropriate for class treatment.

133 F.3d at 398.

Plaintiffs' estoppel claim, which is pled on a class basis, flies in the face of the teaching of Sprague. See also Frahm v. Equitable Life Assurance Soc'y, 137 F.3d 955,

957 (7th Cir. 1998); Cooke v. Manufactured Homes, Inc., 998 F.2d 1256, 1261 n.5 (4th Cir. 1993). As noted above, sixteen of the twenty-one Plaintiffs cannot possibly have relied on those March and April 2001 Resolutions because they all retired, or their spouses retired, at least six years before those Resolutions. The estoppel claims of the five remaining Plaintiffs depend on unique facts and circumstances of those individual Plaintiffs, and no effort has been made to set out those facts and circumstances. Such particularized allegations are especially important in this case because, to the extent that any individual Plaintiff claims to have received and relied to his or her detriment upon statements or promises allegedly made by INTELSAT/IGO, any estoppel claim, even against Intelsat Service, would be barred by INTELSAT/IGO's immunity as previously discussed.

In addition, the existence of the June 2001 Summary Plan Description and its clear plan terms also bars any estoppel claims against Intelsat Service as a matter of law. Under ERISA, estoppel claims may not be asserted to vary an ERISA plan's terms where, as here, the plan terms are unambiguous. Sprague, 133 F.3d at 404; Wilson v. Prudential Ins. Co., 97 F.3d 1010 (8th Cir. 1996); Fink v. Union Cent. Life Ins. Co., 94 F.3d 489 (8th Cir. 1996). In this case, the Intelsat Plan's terms clearly do not provide continued lifetime coverage to surviving spouses of deceased retirees but do permit such surviving spouses to elect COBRA coverage and to have conversion rights thereafter. Despite these clear and unambiguous terms of the June 2001 Summary Plan Description, the surviving spouse Plaintiffs are claiming an ERISA right to continuing coverage based on non-plan documents that purport to vary the terms of the ERISA Intelsat Plan. Such estoppel

claims are not cognizable under the federal common law of ERISA and therefore should be dismissed.

V. Count IV Fails to Satisfy the Pleading Standard of Fed. R. Civ. P. Rule 9(b).

Rule 9(b) requires that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake . . . shall be stated with particularity." As the D.C. Circuit has articulated the test, Rule 9(b) requires that the allegations state the "time, place and content of the false misrepresentations, the fact misrepresented and what was retained or given up as a consequence of the fraud." Kowal v. MCI Communications Corp., 16 F.3d 1271, 1277 (D.C. Cir. 1994)(quoting United States ex rel. Joseph v. Cannon, 642 F.2d 1373, 1385 (D.C.Cir.1981), cert. denied, 455 U.S. 999 (1982)). See 5 CHARLES ALAN WRIGHT AND ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 1297 (2d ed.1990).

Although the Complaint quotes various statements made at various times by various entities and persons, none of these statements, except the October Statement, was made by the Defendants. Furthermore, the Complaint fails to identify which "facts" in these statements are "false" and "misrepresented," and "what was retained or given up as a consequence of the fraud." More fundamentally, the Complaint fails to identify which of the various statements are alleged to be fraudulent and to specify which, if any, statement a Defendant in this case made that supports this claim, or why such statement may be fraudulent. Count IV alleges that the Defendants "did not intend to fulfill" certain unidentified "promises and representations" that were made by INTELSAT/IGO, thus rendering those promises "false," deceptive, and made with the intent that plaintiffs rely on them. ¶ 65. As set forth above, however, any statements made by INTELSAT/IGO

about projected health benefits that Intelsat Service might provide could not suffice to create enforceable "vested" rights. Such projections must be accompanied by specific allegations that they lacked any reasonable basis and were made in bad faith. See Kowal. With regard to the October Statement, the Complaint lacks specificity as to which of the four Plaintiffs who retired after it was made actually relied on specific allegedly false statements in that October Statement. Such "lumping together" of allegedly fraudulent statements by unspecified speakers is precisely the sort of vagueness that Rule 9(b) prohibits. Consequently, Count IV should be dismissed.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that the Plaintiffs' Complaint be dismissed.

/s/ David R. Warner

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Certificate of Service

I HEREBY CERTIFY that on this 18th day of October, 2004, the foregoing Memorandum in Support of Defendants' Motion to Dismiss was electronically filed and served by first class mail on:

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Attorney for Plaintiffs

/s/ David R. Warner
David R. Warner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PATRICIA ACOSTA, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	CIVIL ACTION NUMBER. 1:04CV01618
	)	JUDGE: James Robertson
INTELSAT GLOBAL SERVICE CORP., et al.,	)	
	)	
	)	
Defendants.	)	

ORDER

Upon consideration of the Motion to Dismiss filed by Defendants Intelsat Global Service Corporation, Intelsat, Ltd., and Kathleen Alexander, Administrator, the response, and reply thereto, it is this __ day of _____, 200_, ORDERED:

1. That the Motion be, and hereby is, GRANTED; and

2. That the Complaint be, and hereby is, DISMISSED with prejudice.

_____
Honorable James Robertson
Judge, United States District Court for the District of Columbia

EXHIBIT A

RESTRUCTURING AGREEMENT

among

THE INTERNATIONAL TELECOMMUNICATIONS SATELLITE ORGANIZATION
"INTELSAT"

INTELSAT, LTD.

INTELSAT (BERMUDA), LTD.

INTELSAT U.K., LTD.

INTELSAT SERVICES CORPORATION

INTELSAT HOLDINGS LLC

INTELSAT LLC

SIGNATORIES OF INTELSAT NAMED ON SCHEDULE I

INVESTING ENTITIES OF INTELSAT NAMED ON SCHEDULE II

Dated as of July 17, 2001

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ANNEXES, SCHEDULES AND ATTACHMENTS

Section 9.03. Assignment. No party to this Agreement may assign any of its rights or obligations under this Agreement without the prior written consent of the other parties hereto (which consent shall not be unreasonably withheld or delayed). Any attempted assignment in contravention hereof shall be null and void; *provided, however*, that such consent shall not be required if a Signatory Party or Investing Party transfers any of its rights or obligations hereunder (a) on or prior to the Closing Date, to a successor Signatory or Investing Entity, as the case may be, or (b) after the Closing Date, to any entity that is a successor entity in any merger or corporate reorganization of such Signatory Party or Investing Party, or the transferee of or successor to all or substantially all of the assets of such Signatory Party or Investing Party; and *provided, further*, that such consent shall not be required in the case of any of the Intelsat Entities if, after the Closing Date, such Intelsat Entity transfers any of its rights or obligations hereunder to any transferee of, or successor to, all or

substantially all of the assets of such Intelsat Entity. No such assignment shall relieve any party of its obligations hereunder.

Section 9.04. Entire Agreement. This Agreement and the other Transaction Agreements (including the Schedules, Annexes and Exhibits hereto and thereto) contain the entire agreement among the parties hereto and thereto with respect to the subject matter hereof and thereof and supersede all prior agreements and understandings, oral or written, with respect to such matters.

Section 9.05. Successors and Assigns. This Agreement and each of the other Transaction Agreements shall inure to the benefit of, and be binding upon, the parties hereto and thereto and their respective successors and permitted assigns. Except as set forth in Section 9.03, nothing in this Agreement or any other Transaction Agreement, express or implied, is intended to confer upon any Person other than the parties hereto, their successors or permitted assigns, any rights or remedies under or by reason of this Agreement or any other Transaction Agreement.

Section 9.06. Choice of Law; Jurisdiction and Service of Process; Waiver. (a) THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK, U.S.A. SUBJECT TO SECTION 9.06(c), EACH PARTY HERETO AGREES THAT ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AGREEMENT, THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, AT LAW OR IN EQUITY, SHALL BE INSTITUTED BY ANY PARTY TO THIS AGREEMENT, THE TRUSTEE OR THE COLLATERAL TRUSTEE IN ANY NEW YORK STATE OR UNITED STATES FEDERAL COURT SITTING IN THE BOROUGH OF MANHATTAN, THE CITY OF NEW YORK, U.S.A. (THE "CHOSEN COURTS"), AND EACH PARTY TO THIS AGREEMENT EXPRESSLY ACCEPTS AND SUBMITS TO THE EXCLUSIVE JURISDICTION OF ANY SUCH COURT IN RESPECT OF ANY SUCH ACTION. EACH PARTY TO THIS AGREEMENT (I) WAIVES ANY OBJECTION TO LAYING VENUE IN ANY SUCH ACTION OR PROCEEDING IN THE CHOSEN COURTS, (II) WAIVES ANY OBJECTION THAT THE CHOSEN COURTS ARE AN INCONVENIENT FORUM OR DO NOT HAVE JURISDICTION OVER ANY PARTY HERETO AND (III) AGREES THAT SERVICE OF PROCESS UPON SUCH PARTY IN ANY SUCH ACTION OR PROCEEDING SHALL BE EFFECTIVE IF NOTICE IS GIVEN IN ACCORDANCE WITH THIS SECTION 9.06. EACH PARTY HERETO IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY SOVEREIGN OR OTHER IMMUNITY FROM JURISDICTION OR FROM EXECUTION (EXCEPT THAT SUCH PARTY DOES NOT WAIVE IMMUNITY FROM EXECUTION PRIOR TO JUDGMENT AND ANY SIMILAR DEFENSE) TO WHICH IT MIGHT OTHERWISE BE ENTITLED IN ANY SUCH ACTION WHICH MAY BE INSTITUTED IN ANY CHOSEN COURT BY ANY OTHER PARTY TO THIS AGREEMENT, THE TRUSTEE OR THE COLLATERAL TRUSTEE.

(b) Each party hereto, at its own expense, hereby appoints the entity named in Schedule XIII hereto and whose address (also set forth in Schedule XIII) is located in the Borough of Manhattan, The City of New York, the State of New York, U.S.A. or, in the absence of an entity being so named in such Schedule, hereby appoints CT Corporation System, 111 Eighth Avenue, New York, New York 10011, U.S.A., as its authorized agent (the "Authorized Agent") upon which process may be

served in any action arising out of or relating to this Agreement or the transactions contemplated by this Agreement, which may be instituted in any Chosen Court by another party to this Agreement, the Trustee or the Collateral Trustee. Such appointment shall be irrevocable until December 31, 2002. Each party hereto hereby irrevocably waives any immunity to service of process in respect of any such action to which it might otherwise be entitled in any action arising out of or relating to this Agreement or the transactions contemplated by this Agreement which may be instituted in any Chosen Court by another party to this Agreement or by the Trustee. Service of process upon the Authorized Agent at the address indicated above, as such address may be changed within the Borough of Manhattan, The City of New York, the State of New York, U.S.A., by notice given by the Authorized Agent to each party hereto, shall be deemed, in every respect, effective service of process upon each other party hereto.

(c) Notwithstanding Sections 9.06(a) and (b) hereof, a Signatory Party or Investing Party identified on Schedule XIV hereto (a "Prohibited Party") that is prohibited pursuant to an applicable Law from (i) being party to an agreement that specifies that the governing law of the agreement will be the laws of the State of New York, U.S.A. or (ii) submitting to the jurisdiction of the Chosen Courts, shall not be subject to Sections 9.06(a) and (b), but shall be subject to the dispute resolution procedures set forth in Annex D hereto. Each party to this Agreement agrees that any dispute, controversy or claim between such party and a Prohibited Party arising out of or relating to this Agreement or the transactions contemplated by this Agreement shall be subject to the dispute resolution procedures set forth in Annex D.

EXHIBIT B

TRANSFER AGREEMENT

among

THE INTERNATIONAL TELECOMMUNICATIONS SATELLITE ORGANIZATION
"INTELSAT"

INTELSAT, LTD.

INTELSAT (BERMUDA), LTD.

INTELSAT U.K., LTD.

INTELSAT SERVICES CORPORATION

INTELSAT HOLDINGS LLC

INTELSAT LLC

Dated as of July 17, 2001

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Annex and Schedules

Section 11.04. Entire Agreement. This Agreement and the Restructuring Agreement (including the Schedules, Annexes and Exhibits hereto and thereto) contain the entire agreement among the parties hereto and thereto with respect to the subject matter hereof and thereof and supersede all prior agreements and understandings, oral or written, with respect to such matters.

Section 11.05. Successors and Assigns; Third Party Beneficiaries.

(a) This Agreement shall inure to the benefit of, and be binding upon, the parties hereto and thereto and their respective successors and permitted assigns. Nothing in this Agreement, express or implied, is intended to confer upon any Person other than the parties hereto, the Signatories and the Investing Entities, and their respective successors or permitted assigns, any rights or remedies under or by reason of this Agreement or any other Transaction Agreement.

(b) The Signatory Parties and Investing Parties and their respective successors and permitted assigns under the Restructuring Agreement are intended third party beneficiaries of this Agreement, and the Signatories and the Investing Entities and their respective successors and assigns are intended third party beneficiaries of Section 2.07 of this Agreement.

Section 11.06. Choice of Law; Jurisdiction; Service of Process; Waiver.

(a) THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK, U.S.A. EACH PARTY HERETO AGREES THAT ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE

TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, AT LAW OR IN EQUITY, SHALL BE INSTITUTED BY ANY PARTY TO THIS AGREEMENT IN ANY NEW YORK STATE OR UNITED STATES FEDERAL COURT SITTING IN THE BOROUGH OF MANHATTAN, THE CITY OF NEW YORK, U.S.A. (THE "CHOSEN COURTS"), AND EACH PARTY TO THIS AGREEMENT EXPRESSLY ACCEPTS AND SUBMITS TO THE EXCLUSIVE JURISDICTION OF ANY SUCH COURT IN RESPECT OF ANY SUCH ACTION. EACH PARTY TO THIS AGREEMENT (I) WAIVES ANY OBJECTION TO LAYING VENUE IN ANY SUCH ACTION OR PROCEEDING IN THE CHOSEN COURTS, (II) WAIVES ANY OBJECTION THAT THE CHOSEN COURTS ARE AN INCONVENIENT FORUM OR DO NOT HAVE JURISDICTION OVER ANY PARTY HERETO AND (III) AGREES THAT SERVICE OF PROCESS UPON SUCH PARTY IN ANY SUCH ACTION OR PROCEEDING SHALL BE EFFECTIVE IF NOTICE IS GIVEN IN ACCORDANCE WITH THIS SECTION 11.06. EACH PARTY HERETO IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY SOVEREIGN OR OTHER IMMUNITY FROM JURISDICTION OR FROM EXECUTION (EXCEPT THAT SUCH PARTY DOES NOT WAIVE IMMUNITY FROM EXECUTION PRIOR TO JUDGMENT AND ANY SIMILAR DEFENSE) TO WHICH IT MIGHT OTHERWISE BE ENTITLED IN ANY SUCH ACTION WHICH MAY BE INSTITUTED IN ANY CHOSEN COURT BY ANY OTHER PARTY TO THIS AGREEMENT.

(b) Each party hereto, at its own expense, hereby appoints CT Corporation System, 111 Eighth Avenue, New York, New York 10011, U.S.A, as its authorized agent (the "Authorized Agent") upon which process may be served in any action arising out of or relating to this Agreement or the transactions contemplated by this Agreement, which may be instituted in any Chosen Court by another party to this Agreement. Such appointment shall be irrevocable until December 31, 2002. Each party hereto hereby irrevocably waives any immunity to service of process in respect of any such action to which it might otherwise be entitled in any action arising out of or relating to this Agreement or the transactions contemplated by this Agreement which may be instituted in any Chosen Court by another party to this Agreement or by the Trustee. Service of process upon the Authorized Agent at the address indicated above, as such address may be changed within the Borough of Manhattan, the City of New York, the State of New York, U.S.A., by notice given by the Authorized Agent to each party hereto, shall be deemed, in every respect, effective service of process upon each other party hereto.

EXHIBIT C

CONFIDENTIAL

ATTACHMENT NO. 1 to
CPD-114 Q/3/01
Page 1

RESOLUTION ON RETIREE MEDICAL BENEFIT PROTECTION

WHEREAS, retired staff members of the International Telecommunications Satellite Organization ("INTELSAT") are currently eligible to receive medical, dental, vision, and prescription drug coverage for themselves and their eligible dependents under a health care plan maintained by INTELSAT; and

WHEREAS, health care coverage for INTELSAT retirees is provided as of 1 January 2001 under the CareFirst BlueCross BlueShield plan ("CareFirst Plan") (draft copy available upon request); and

WHEREAS, retirees are required to contribute toward the cost of coverage provided to them under the CareFirst Plan; and

WHEREAS, effective on or after 18 July 2001 ("Privatization Date"), INTELSAT will become a privatized entity by transferring substantially all of its assets, liabilities, and staff members to Intelsat Ltd and its subsidiaries, including Intelsat Services Corporation ("ISC "), a Delaware corporation, and

WHEREAS, ISC will be assuming sponsorship of the CareFirst Plan and other benefit plans maintained by INTELSAT; and Intelsat Ltd shall guarantee its benefits; and

WHEREAS, INTELSAT retirees have expressed concerns about the potential impact of privatization on the health care benefits currently being provided by the CareFirst Plan; and

WHEREAS, INTELSAT desires to guarantee that the health care benefits now being provided to retirees will not be reduced or impaired as a result of INTELSAT's privatization;

NOW, THEREFORE, BE IT RESOLVED as follows:

1. This Resolution shall apply to the following persons: (a) all INTELSAT retirees who are participating in the CareFirst Plan as of the Privatization Date ("Protected Retirees"); (b) all spouses and dependents of Protected Retirees who are enrolled in such plan as of the Privatization Date and thereafter remain eligible for coverage under the terms of such plan or who become eligible for coverage after the Privatization Date pursuant to the terms of the CareFirst Plan ("Protected Dependents"); (c) all INTELSAT employees who will be eligible to retire under the terms of the Staff Retirement Plan and eligible to participate in retiree medical benefits on or before the date of privatization ("Eligible Retirees") regardless of whether they actually retire before that date; and (d) all spouses and dependents of the Eligible Retirees who are eligible to enroll in such plan

upon the Eligible Retiree's actual retirement date and thereafter remain eligible or who thereafter become eligible for such coverage under the terms of the CareFirst Plan ("Eligible Dependents"). The Protected Retirees and Protected Dependents shall continue to receive the benefit coverage provided under the CareFirst Plan as of 1 January 2001 or its substantial equivalent (throughout this document, "substantial" shall mean "no material change") ("Protected Benefits"). Upon their actual retirement, Eligible Retirees and Eligible Dependents will be entitled to participate in the same Protected Benefits on the same terms as the Protected Retirees and Protected Dependents, and those benefits are hereby vested in the Eligible Retirees and Eligible Dependents. Neither INTELSAT, ISC nor any successor shall have the right to terminate or reduce in any material respect the Protected Benefits for any retiree or dependent covered by this Resolution, and those benefits are hereby vested in the Protected Retirees and Eligible Retirees and Protected Dependents and Eligible Dependents. ISC shall be the plan sponsor, and Intelsat Ltd shall be the guarantor, guaranteeing to pay the benefits. ISC agrees that, upon privatization, it will be bound by the provisions of the Employee Retirement Income Security Act ("ERISA").

2. INTELSAT and/or ISC can correct the draft plan so as to correctly reflect the current (as of January 1, 2001) benefits, administration, and plan features. The final plan document shall be that issued to employees and retirees on or before privatization, which shall reflect the benefits, administration and plan features as of January 1, 2001. INTELSAT and its successors shall have the sole right and authority to determine how the Protected Benefits will be provided, either through the CareFirst Plan or through one or more replacement benefit programs, including, but not limited to, the right to contract with one or more different insurance companies or to insure or self-insure the Protected Benefits in whole or in part. Notwithstanding the foregoing, any replacement benefit program shall not be less favorable in any material respect to Protected Retirees, Protected Dependents, Eligible Retirees, and Eligible Dependents than the CareFirst Plan. The Protected Benefits will include network providers that are substantially comparable (in terms of the range of choice of and quality of medical providers) to those available on January 1, 2001; and a methodology and practice of determining reasonable and customary charges, where applicable, and other administrative issues, that is substantially comparable to those used on January 1, 2001.

3. Nothing contained in this Resolution shall obligate INTELSAT, ISC, or any successor to provide Protected Benefits in a manner that is inconsistent with any applicable legal requirements under federal, state, or other relevant law. Further, nothing contained herein shall prevent INTELSAT, ISC, or any successor from modifying the Protected Benefits to the extent necessary to comply with any applicable legal requirements under any current or future federal, state, or other relevant law, including any regulations and other regulatory guidance issued pursuant thereto. Any action or

modification needed to comply with applicable legal requirements shall be made in a manner that to the maximum extent possible maintains the level of benefits and rights for the retirees and dependents covered by this Resolution.

4. Nothing in this Resolution shall be construed to prohibit INTELSAT, ISC, or any successor from requiring retirees to contribute toward the cost of coverage by increasing the amount of retiree premiums at any time in the future, provided that no more than one such increase may be made in a calendar year and provided further that the retiree premium required for any coverage option in any future calendar year shall not exceed the premium charged for that option as of 1 January 2001 multiplied by a fraction, the numerator of which is the United States Bureau of Labor Statistics Consumer Price Index for All Urban Consumers, Washington-Baltimore, D.C.-MD-VA-WV ("CPI-U DC-Baltimore Index"), for November of the year immediately preceding the relevant calendar year divided by the CPI-U DC- Baltimore Index for November 2000. As of 1 January 2001, retirees pay the following amounts for each covered individual (up to a maximum family premium of three times the individual rate):

a. Primary coverage under Preferred Provider Option: $50 per month;

b. Secondary coverage under Preferred Provider Option: $25 per month;

c. Primary coverage under Capital Choice option: $30 per month; and

d. Secondary coverage under Capital Choice Option: $15 per month.

If the $1,000,000 maximum lifetime benefit limit is increased for employees, it shall also be increased in the same amount for all retirees and their dependents covered by this Resolution.

5. This Resolution shall be incorporated into the asset transfer documents that will effect the INTELSAT privatization as a condition of the transfer. The benefits and rights provided herein shall be a vested ERISA covered plan established and maintained by ISC, and its successors, and guaranteed by Intelsat Ltd and its successors. The commitments made in this Resolution shall remain a continuing obligation of ISC, Intelsat Ltd, and their successors until the death of the last surviving retiree or dependent covered by this Resolution. To the extent that any provision in this Resolution conflicts with a provision of the asset transfer documents, the terms of this Resolution shall control with respect to the rights and obligations of INTELSAT, Intelsat Ltd, ISC and their successors, and the retirees and dependents covered by this Resolution.

6. Notwithstanding any preceding provision to the contrary, this Resolution is contingent upon the privatization of INTELSAT through the transfer of assets and liabilities to Intelsat Ltd and its subsidiaries, including ISC.

7. If the consolidated net worth of Intelsat Ltd or its successors, who have the continuing obligations under this Resolution and the plan ("the Entity") falls below $500 million dollars as evaluated in the Entity's audited financial statements, quarterly reports to shareholders or owners, or as reported to the Securities and Exchange Commission (or equivalent reports if these financial statements do not exist), the Entity within 30 days shall: (a) establish an Irrevocable Trust to accept funds for the Protected Benefits, with the same Trustee and Committee as the pension plan trust, with the Committee acting as the fiduciary for the plan. To the extent possible under the federal tax law existing at the time the trust is established, the trust shall be established and maintained, in whole or if necessary in part, as a tax-exempt trust, such as a Voluntary Employees' Beneficiary Association (VEBA) trust qualified under section 501(c)(9) of the U.S. Internal Revenue Service Code (sample trust document available on request); and (b) obtain a one-year letter of credit from a federally-insured bank which has adequate financial resources, payable to the Irrevocable Trust, equal to 150% of the then FASB (United States Financial Accounting Standards Board) valuation of the liability for the Protected Benefits. If the Entity's net worth, evaluated as above, increases to $500 million or above, and remains at that level for at least six months, the Entity may cancel the letter of credit. If the Entity fails to obtain the letter of credit as provided for herein, the Entity within 10 days of its failure must transfer funds to the Irrevocable Trust equal to 150% of the then FASB valuation of the liability for the Protected Benefits. The letter of credit must be renewed each year in the amount of 150% of the FASB valuation at the time of renewal of the liability for the benefits herein. If the Entity's net worth falls below $300 million, or if the letter of credit is not renewed within 3 months before its expiration date, the Irrevocable Trust can and will exercise the letter of credit in its full amount, and the funds shall be placed in the Irrevocable Trust. The right to require and exercise the letter of credit shall be a part of the ERISA plan, and an asset of the plan, and its accompanying trust. The Entity shall provide the INTELSAT Retirees Association at its last known address with a copy of any letter of credit required herein. ISC or its successor shall inform any beneficiary under the plan, upon request, how they can get a copy of the financial statements and reports referenced herein and a copy of the letter of credit

Notwithstanding the foregoing, no Protected Benefits shall be provided through a trust created pursuant to this Paragraph 7 on behalf of any Eligible Retiree who did not retire prior to privatization, or the eligible spouse or dependent of any such individual, if the Eligible Retiree was at any time a "key employee" within the meaning of section 416(i) of the Internal Revenue Code. The Protected Benefits with respect to any such key

employee, spouse, or dependent shall not be included for purposes of determining the FASB valuation of the liability for Protected Benefits that may otherwise be required under this Paragraph 7.

Nothing contained in this Paragraph 7 shall obligate the Entity to take any action that would (a) cause the Entity to violate any applicable legal requirements under federal, state, or other relevant law; or (b) cause any retirement plan maintained by the Entity for the benefit of its eligible employees to cease to qualify as a qualified plan under section 401(a) of the Internal Revenue Code. If the creation of the trust or exercise of the letter of credit will impose tax liability on either the Entity or the Protected Retirees, Eligible Retirees, Protected Dependents, and Eligible Dependents, the Committee can exercise its discretion to act in a manner which minimizes the tax liability while providing as much financial security as possible, *i.e.*, balancing the tax and security interest to get the best result for the Protected Retirees, Eligible Retirees, Protected Dependents, and Eligible Dependents. Any tax on the Entity shall reduce the amount given to the trust.

EXHIBIT D

A

SUMMARY

OF YOUR MEDICAL BENEFITS

AND

HOW TO USE THEM

PREPARED FOR

THE EMPLOYEES OF

Intelsat Services Corporation

TABLE OF CONTENTS

FOR YOUR REFERENCE

- Member Services Representatives are available to answer benefit and claim inquiries Monday through Friday from 9:00 a.m. until 5:00 p.m., Eastern Standard Time (EST). In addition, a Voice Response Unit (VRU) is available from 7:00 a.m. to 11:00 p.m. EST, Monday through Friday and from 9:00 a.m. to 5:00 p.m. EST, Saturday for claims status and claim form requests. Please contact Member Services at 202-479-6099 or 800-424-7474, Ext. 6099.

- You can also send written inquiries to Member Services at:

  CareFirst BlueCross BlueShield
  550 12th Street, SW
  Washington, DC 20065

- To authorize medical services, please contact Utilization Management at 202-479-6718 or 800-553-8700.

- For other inquiries regarding your health insurance coverage, you may contact the Group Administrator at 202-944-7513.

- You may also send inquiries to:
  Intelsat Services Corporation
  Human Resources
  3400 International Drive, NW
  Box 24
  Washington, DC 20008

INTRODUCTION

Intelsat Services Corporation is pleased to offer you and your family access to health care coverage. The Preferred Provider Option (PPO), administered by CareFirst BlueCross BlueShield (CareFirst), enables you to choose how to receive services based on your health care needs.

Overview

This Summary Plan Description (SPD) describes the benefits offered under the PPO program. SPDs are required for certain benefits under the law. As a member of this benefit plan, you are entitled to certain rights outlined in this SPD.

Keep this SPD in a handy location, so that you can refer to it when necessary. Refer to it when you need to find out information quickly or if you just want to know what your coverage includes.

If you have a question regarding your PPO coverage that is not covered in this SPD, call Member Services at 202-479-6099 or toll-free at 800-424-7474, Ext. 6099. You can also call the Group Administrator at 202-944-7513 if you have questions. However oral representations inconsistent with the Plans terms are not binding.

How to Use this SPD

This SPD is meant to be informative and easy to understand. It was written to help you learn how your benefits work and how to use them most effectively. Please take some time to read through the SPD. When faced with a benefit question, you will know where to turn in the SPD for your answer.

The information provided in this SPD summarizes your benefit plan. It does not contain all of the details described in the official plan documents. If there is a discrepancy between what is summarized here and the official plan documents, *the plan documents will govern.* Intelsat Services Corporation reserves the right to change, amend or terminate the program at any time for all participants. This SPD is not a contract and participation in this plan does not guarantee employment.

Important Information

Intelsat Services Corporation has entered an Administrative Services Contract with CareFirst BlueCross BlueShield. Under the terms of the Contract, Intelsat Services Corporation is responsible for payment of your medical expenses. CareFirst BlueCross BlueShield merely administers the Program for Intelsat Services Corporation. Should Intelsat Services Corporation be unable to pay for your medical expenses, you may not seek payment from CareFirst BlueCross BlueShield.

1.	Plan Administrator:	Intelsat Services Corporation 3400 International Drive Washington, DC 20008 202-944-7513
2.	Plan Contact:	Human Resources 202-944-7513
3.	Type of Plan:	Health Benefits Program
4.	Employer ID Number:	52-2293595
5.	Plan Number:	501
6.	Plan Year:	The plan year begins January 1 and ends the following December 31. Records are kept on a calendar year basis.
7.	Claims Administrator:	CareFirst BlueCross BlueShield 550 12th Street, SW Washington, DC 20065
8.	Member Services Telephone #:	202-479-6099 or 800-424-7474, Ext. 6099
9.	Type of Administration:	The benefits of this plan are self-insured by Intelsat Services Corporation and claims are processed through a contract with CareFirst BlueCross BlueShield.
10.	Agent for Legal Process:	Intelsat Services Corporation 3400 International Drive Washington, DC 20008
11.	Source of Contribution:	Employer and employee

Statement of ERISA Rights

As a participant in the Intelsat Services Corporation plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all plan documents and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may assess a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for benefits is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington DC 20210.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law protects workers who change jobs or lose jobs, limits preexisting condition exclusion periods, eliminates permanent health exclusions in the group market, prohibits discrimination against employees and dependents based on health status, and guarantees renewability of health coverage to employers and individual members. The following are answers to some commonly asked questions concerning HIPAA.

Under HIPAA, when an employee joins a group, all prior coverage (whether in an earlier employer group or Individual policy) is credited toward the new health plan's preexisting condition waiting period as long as the member has not had a break of 63 days or more between any old and new coverage.

HIPAA Questions and Answers

Who is covered by HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) primarily applies to members who have health coverage through a **group** health plan. It affects employees when they leave one employer group and go to another. It also affects some employees when they leave their group and take individual coverage.

How will newly hired employees prove they had prior creditable coverage?

In general, the employee's former employer, group health plan and/or insurance company is responsible for providing a certificate as proof of an employee's prior coverage, usually by issuing a certificate of creditable coverage.

How can a member receive a Certificate of Coverage?

CareFirst automatically sends certificates to members who terminate coverage.

Does COBRA count toward creditable coverage?

Yes.

How did the law change COBRA requirements?

Effective January 1, 1997, the new law

- Clarifies that disabled beneficiaries of covered employees are eligible for the maximum coverage period of 29 months.
- Provides for extended coverage if a (former) employee becomes disabled during the first 60 days of COBRA coverage.
- Allows termination of COBRA coverage for an individual who is actually covered under a new group health plan.
- Extends the definition of a qualified beneficiary to include a child born to or adopted by the employee while covered under COBRA.

CAREFIRST BLUE CROSS BLUESHIELD

SELF-INSURED PROGRAM

550 12th Street, SW
Washington, DC 20065

Welcome to the CareFirst BlueCross BlueShield ("CareFirst") Program. Eligible individuals may select coverage through either a PPO Program Option (Attachment A) or a Point-of-Service Program Option and may change the Program Options in which they are enrolled at designated times and under certain conditions as explained in Section 2.8. All enrolled Members are covered under the Self-Insured Prescription Drug Program (Attachment C) and the Self-Insured Dental Program. In addition, Eligible Employee/Members of the Group who are enrolled in the Group's Alternate Health Plan (as defined in Section 1) may enroll in the Self Insured Dental Program.

This Program Description is intended to describe how the Program works. It, along with any amendments, describes the terms and conditions of the benefits arrangement through which CareFirst provides services.

This Program Description is part of an Administrative Services Contract ("Contract") between the Group and CareFirst. That Contract sets forth and explains the duties and obligations of CareFirst and the Group and is the complete contract between CareFirst and the Group. The Group accepts and agrees to the Contract by making payment to CareFirst as required under the Contract. CareFirst agrees to the Contract when it issues the Contract to the Group. The Group's payment and CareFirst's issuance of the Contract make the Contract's terms and provisions binding on CareFirst and the Group.

SECTION 1
DEFINITIONS

The Program uses certain defined terms. When these words are capitalized, they have the following meanings.

1.1 Alternate Health Plan means any other program of medical, surgical, hospital and other covered health benefits, which the Group makes available to Eligible Employee/Members as an alternative to enrollment in this Program.

1.2 Contract means the agreement issued by CareFirst to the Employee/Member's Group through which the Program benefits described in this Program Description are administered to the Employee/Member and his or her enrolled Dependents, if any. In addition to this Description, the Contract includes an Administrative and Claims Services Agreement, the Employee/Member's Enrollment Application, any Amendments, and the Summary Plan Description.

1.3 Eligible Employee/Member means persons who meet the eligibility rules in Section 2.2.

1.4 Enrollment Application means the information submitted by or on behalf of an eligible individual in connection with a request to enroll under the Contract as either an Employee/Member or a Dependent.

1.5 Group means the Employee/Member's Program employer to which CareFirst has issued the Contract.

1.6 Member means an individual who meets all applicable eligibility requirements of Section 2, is enrolled for coverage, and for whom CareFirst receives the required payments. A Member can be either an Employee/Member, a Dependent or a Domestic Partner.

a. **Employee/Member** means a Member who is enrolled under this Program by virtue of his or her being an eligible employee or retiree of the Group, rather than as a Dependent.

b. **Dependent** means a Member who is enrolled under this Program as the spouse, domestic partner, or eligible child of an Employee/Member.

c. **Domestic Partner** means a Member who is enrolled under this Program as a Domestic Partner of an Employee/Member

1.7 Plan Administrator means the Group, or a person designated by the Group, to serve as administrator.

1.8 Point-of-Service Program Option means the coverage that is available to Members who elect to enroll in the Point-of-Service Option. The Point-of-Service Option offers two benefit level options: an In-Network Option that provides HMO-type benefits; and an Out-of-Network Option that provides indemnity-type benefits. Point-of-Service means that each time Members receive covered services, they can choose to see their Primary Care Physician and obtain In-Network benefits or choose to go to an Out-of-Network Provider.

1.9 PPO Program Option means the coverage, as described in Attachment A that is available to Members who elect to enroll in the PPO Program Option. Members enrolled in the PPO Program Option may receive covered services from either a PPO-Network provider or from a non-PPO-Network Provider.

1.10 Program Description means this document describing the Program. In addition, this Program Description may include one or more Amendments.

1.11 Summary Plan Description means the summary description of the Program provided to all Members. In the event of a conflict between the summary description and this complete Program Description, the language of this Program Description governs.

1.12 Type of Coverage means

a. Self-Only Coverage, which covers the Employee/Member only; or

b. Family Coverage, which covers the Employee/Member and two or more Dependents

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. To be covered, a person must meet all of the following conditions:

a. He or she must be **eligible** for coverage either as an Employee/Member under Section 2.2 below, as a spouse or domestic partner under Section 2.3 below, or as a Dependent Child under Sections 2.4 and 2.5 below.

b. He or she must **apply** for coverage by submitting an Enrollment Application to the Group during certain periods set aside for this purpose as described in Section 2.6, below; and

c. The Group must notify CareFirst of such person's enrollment.

In addition, the Employee/Member must elect to enroll in either the PPO Program Option or the Point-of-Service Option, in accordance with Section 2.9, below.

2.2 Eligibility as an Employee/Member. The following individuals are eligible to enroll as Employee/Members:

a. Employees who work a minimum of 24 hours per week;

b. Retirees who, under the Group's rules, are eligible for continued coverage under this Program as a retiree; and

c. Disabled employees who, under the Group's rules, are eligible for continued coverage under this Program.

The Group is required to administer these requirements in strict accordance with the terms that have been agreed to between CareFirst and the Group, and the Group cannot change the requirements or make an exception unless CareFirst approves them in advance, in writing.

2.3 Eligibility of Employee/Member's Spouse or Domestic Partner. An Employee/Member may enroll his or her legal spouse or Domestic Partner (as defined below) as a Dependent. An Employee/Member cannot cover his or her spouse if divorced or if the marriage has been annulled. If an Employee/Member is separated but still legally married, his or her spouse may still be covered. An Employee/Member's Domestic Partner cannot be covered if the partnership no longer meets the requirements listed below.

a. **"Domestic Partner"** means a person of the same sex who cohabitates with the Employee/Member in a Domestic Partnership.

b. **"Domestic Partnership"** means a relationship between a Domestic Partner and an Employee/Member that satisfies the following requirements:

- The Employee/Member and Domestic Partner are each other's sole domestic partner and intend to remain so indefinitely.
- Neither the Employee/Member or Domestic Partner is married to anyone else.
- The Employee/Member and Domestic Partner are at least eighteen years of age and mentally competent to consent to contract.
- The Employee/Member and Domestic Partner are engaged in a committed relationship of mutual caring and support and are jointly responsible for their common welfare and living expenses.
- The Employee/Member and Domestic Partner are not related by blood so close as to bar them from marrying in the state in which they reside.
- The Employee/Member and Domestic Partner agree to terminate coverage should the relationship between them cease to exist.

2.4 Eligibility of Dependent Children. To be covered as a Dependent Child, the child:

a. Must meet the age requirements described in Section 2.5, below;

b. Must be unmarried; and

c. Must be related to the Employee/Member in one of the following ways:

- the Employee/Member's child;
- the Employee/Member's legally adopted child or legal custodial grandchild;
- A child for whom the Employee/Member is the legally recognized proposed adoptive parent and who is a member of the Employee/Member's household and primarily supported by the Employee/Member during the waiting period before the adoption becomes final;
- A stepchild who is a member of the Employee/Member's household and who is primarily supported by the Employee/Member;
- The child of a Domestic Partner who permanently resides in the Employee/Member's household and is dependent upon the Employee/Member for more than half of his or her support.

2.5 Age Limits for Coverage of Dependent Children. An Employee/Member may cover his or her unmarried Dependent Children up to the following age limits:

a. All Dependent Children are eligible up to age 19;

b. Children who are age 19 or over are eligible if attending an accredited school, college or university on a full time basis (a minimum of 12 credit hours per semester) up to the following age limits:

- **Family Coverage.** Student Dependents are eligible under the Employee/Member's Family Coverage to age 25;

The Employee/Member must provide CareFirst with proof of the child's student status within 31 days after the child's 19th birthday or within 31 days after the effective date of the child's coverage under this Program, whichever is later, and annually thereafter. CareFirst has the right to verify whether the child is and continues to qualify as a Student Dependent.

c. A Dependent Child who is age 19 or over will also be eligible if

- The child is incapable of supporting himself or herself because of mental or physical incapacity;
- The mental or physical incapacity occurred before the child reached age 19 or, if the child was covered beyond age 19 as a Student Dependent, the incapacity occurred while the child was a Student Dependent;
- The incapacitated child is chiefly dependent upon the Employee/Member or the Employee/Member's spouse or domestic partner for support and maintenance; and
- The Employee/Member provides CareFirst with proof in writing of the child's incapacity and dependency on the Employee/Member or Employee/Member's spouse or domestic partner, including certification by a physician, within 31 days after the child's coverage would otherwise terminate or within 31 days after the effective date of the child's coverage under this Program, whichever is later. CareFirst has the right to verify whether the child is, and continues to qualify as, an incapacitated child.

2.6 Timely Enrollment Opportunities. This Section discusses when a person may enroll as an Employee/Member or Dependent. If a person meets these conditions, coverage will be treated as a timely enrollment. When a person enrolls, his or her Dependent's coverage under the Program will be effective as explained in Section 2.7 below.

a. **Newly Eligible Employee/Member.** New hires are eligible for coverage on their date of employment or, if other than a new hire, the date on which he or she first became eligible. A Newly Eligible Employee/Member of the Group may enroll prior to or within 31 days following the date he or she first becomes eligible.

b. **Open Enrollment Period.** Prior to January 1 of each year that the Contract is in effect, the Group will have an open enrollment period of between 15 and 31 days' duration. During the open enrollment period, Eligible Employee/Members who are participating under an Alternate Health Plan, as defined in Section 1, may transfer coverage to this Program. This enrollment opportunity applies only to the Employee/Member and Dependents who are currently enrolled in the Alternate Health Plan.

c. **Coverage of a Newborn Child, Newly Adopted Child or Newly Eligible Child or Grandchild with Legal Custody.** Enrollment requirements for an eligible newborn child, a newly adopted child, or a newly eligible child or grandchild for whom the Employee/Member has legal custody depend on the Type of Coverage that is in effect on the date of the child's First Eligibility Date, as defined below. Enrollment requirements for other categories of Dependent Children are described in paragraphs d and e, below.

First Eligibility Date means:

- For a newborn child, the child's date of birth;
- For a newly adopted child, the earlier of:
  - A judicial decree of adoption; or
  - Placement of the child in the Employee/Member's home as the legally recognized proposed adoptive parent.
- For a grandchild for whom the Employee/Member has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later.

Family Coverage. If the Employee/Member already has Family Coverage on the child's First Eligibility Date, the child will be covered automatically as of the child's First Eligibility Date.

Self-Only Coverage. If the Employee/Member has Self-Only Coverage on the child's First Eligibility Date, the child will be covered automatically for the first 31 days following the Child's First Eligibility Date. No action is required to receive this automatic coverage. If the Employee/Member wishes to continue coverage beyond this 31 day period, he or she must enroll the child within 31 days following such child's First Eligibility Date. The change in Type of Coverage will be made effective as of the child's First Eligibility Date. For example, if a child's First Eligibility Date is January 1, the child will automatically receive coverage through January 31. If the Employee/Member wants coverage for the child to continue beyond January 31 the child must be enrolled during the month of January. The change to Family Coverage will be effective as of January 1.

d. **Coverage of Children under Court or Administrative Order.** If the Employee/Member (or another employee who is otherwise eligible for coverage under this Group Contract) is required under a court or administrative order to provide coverage under this Contract for his or her Dependent Child (or Dependent Children), the Employee/Member may enroll the eligible minor Dependent Child (or Dependent Children) included in the order at any time following the date on which the order was signed by a competent court or administrative agency. See Section 2.7.e. regarding when coverage becomes effective. CareFirst will accept such enrollment from any of the following: a) the Employee/Member; or b) the non-employee parent of the Dependent Child.

e. **Other New Dependents.** This paragraph applies to new Dependents, other than those described in paragraphs c. and d., above, such as a new spouse or domestic partner, a newly eligible stepchild, or a newly eligible Primary Care Dependent. If a person is already an Employee/Member, he or she may enroll such family members, and change the Type of Coverage to include the new family member within 31 days following the date the new family member first becomes eligible. This enrollment opportunity applies to the new family member(s), only.

f. **Special Enrollment Periods.** Eligible Employee/Members enroll themselves and/or their dependents under the following qualifying events:

- When the Eligible Employee/Member first became eligible, he or she did not enroll and/or did not enroll his or her Dependents because the Eligible Employee/Member or his or her Dependents already had coverage under a public or private health benefits plan; and that coverage terminates due to any of the following:
  - termination of the other plan's entire group coverage;
  - divorce or legal separation;
  - death of the Employee/Member's spouse or Domestic Partner;
  - voluntary or involuntary termination of the spouse's or Domestic Partner's employment;
  - involuntary loss of the spouse's or Domestic Partner's eligibility for continued group coverage;
  - cancellation of all group health benefits programs offered by the spouse's or Domestic Partner's employer;
  - continuation coverage under Section 3.6 has been exhausted;
  - loss of eligibility for coverage; or
  - employer contribution terminated.

  To qualify for coverage under this provision, the Eligible Employee/Member and each family member that the Eligible Employee/Member seeks to enroll must have been covered on the last day that the prior public or private health plan coverage was in effect. Additionally, the Employee/Member must complete an enrollment form within 31 days after termination of coverage provided under a public or private health benefits plan.

- When the Eligible Employee/Member first became eligible, he or she did not enroll and an individual becomes the Employee/Member's dependent through marriage, birth, adoption or placement for adoption or court-ordered custody, or the Employee/Member must provide coverage through a court or administrative order, the Employee/Member may enroll himself or herself and his or her dependent(s) within 31 days following the occurrence of the qualifying event.

2.7 Effective Dates. Coverage for an Employee/Member or his or her Dependents will become effective as follows:

a. **Newly Eligible Employee/Members.** Coverage for newly Eligible Employee/Members enrolling within the time frame shown in Section 2.6.a. will become effective upon enrollment.

b. **Open Enrollment Period.** Enrollment elected during an Open Enrollment Period will become effective on January 1 following the Open Enrollment Period

c. **Coverage of Newborn Children, Newly Adopted Children and Newly Eligible Children or Grandchildren with Legal Custody.** Coverage will become effective as of the child's First Eligibility Date (as defined in Section 2.6.c.).

d. **Coverage of Children under Court or Administrative Medical Support Order.** Coverage of a Dependent Child under a court or administrative order will become effective on the first day of the month following CareFirst's receipt of the Enrollment Application or as otherwise required by the court or administrative order or applicable law.

e. **Coverage of Other New Dependents**. Coverage of other newly eligible Dependents, e.g., a new spouse or Domestic Partner, stepchild or newly Eligible Primary Care Dependent enrolling within the time frame shown in Section 2.6.e, will become effective on the first day of the calendar month following date first eligible.

f. **Special Enrollment Periods**. Coverage under special enrollment periods described in Section 2.6.f. will be effective upon the occurrence of the qualifying event.

2.8 Selecting and Changing Program Options. When first enrolled in this Program, each Employee/Member must select coverage for himself or herself (and his or her covered Dependents, if any) either under the PPO Program Option or under the Point-of-Service Option. Employee/Members enrolled in the Program may change their selection of a Program Option during the annual enrollment period, described in Section 2.7.b., above. The change in Program Options will become effective on January 1 following the Open Enrollment Period.

2.9 Clerical or Administrative Error. If a person is ineligible for coverage, such person cannot become eligible simply because CareFirst or the Group made a clerical or administrative error and incorrectly recorded or reported the person as eligible. Likewise, if a person is properly eligible for coverage, such person will not lose coverage merely because CareFirst or the Group made an administrative or clerical error and recorded or reported the person as ineligible.

2.10 Cooperation and Submission of Information. CareFirst may require a person and/or the Group to verify eligibility. A Employee/Member, Dependent and the Group are required to cooperate with and assist CareFirst, including allowing it to review records upon request. If a request is sent to the Group and the Group fails to respond within 31 days, CareFirst will then send the Employee/Member a copy of the request and allow him or her an additional 31 days to submit the information or documents directly to CareFirst. If CareFirst does not receive the information and/or documents required to establish eligibility within 31 days, the Plan Administrator may suspend or terminate coverage.

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination of the CareFirst Program. The CareFirst Program may be terminated as follows:

Upon termination of the Contract, benefits for all Members in the Group will end on the last day on which the Contract was in effect. However, if a Member is eligible for the Extension of Benefits under Section 3.5, benefits will end on the last day of such Member's Extension of Benefits period.

3.2 Disenrollment of Individual Members. Except as provided under Sections 3.5 and 3.6 below, coverage of enrolled Members will terminate as follows:

a. Employee/Member coverage and the coverage of enrolled Dependents under the Program, will terminate if:

- the Employee/Member is no longer employed by the Group; or
- the Member no longer meet the eligibility requirements for coverage under the Program as set forth in this Program Description, including any amendments thereto.

The Plan Administrator of the Group's health benefit plan is required to notify a Member if coverage under the Program is canceled. Even if the Plan Administrator does not notify the Member, coverage will nonetheless terminate. Coverage will terminate on the date on which the employment or eligibility ceased.

b. Employee/Member coverage and the coverage of enrolled Dependents under the Program will terminate if the Employee/Member cancels coverage through the Group, or changes to another health benefits option offered by the Group.

c. Except as provided in Section 3.2.d. below, the coverage of Dependents (but not the Employee/Member) will terminate if the Employee/Member:

- Changes the Type of Coverage to a Self-Only Coverage; or
- Makes a written request to CareFirst to remove an eligible Dependent from coverage.

d. If a Dependent Child is enrolled under this Program pursuant to a court or administrative medical support order under Section 2.7.d, the Employee/Member may not terminate or cancel the coverage of such child unless written evidence is provided to the Plan Administrator that:

- The order is no longer in effect; or
- The child has been or will be enrolled under other reasonable health insurance coverage which will take effect not later than the effective date of the disenrollment; or
- The Group has eliminated group family health coverage for all of its employees.

If coverage to the Dependent Child is canceled under this Section 3.2.d, CareFirst is not required to give notice of termination to the Employee/Member or to his or her Dependent Child.

e. The coverage of Dependents will **automatically** terminate if such Dependents no longer meet the eligibility requirements of the Program because of a change in their age, status, relationship to the Employee/Member or other event affecting their eligibility. Coverage for these Dependents will terminate on the date on which the Dependent first became ineligible.

NOTE: The Employee/Member is responsible for notifying the Plan Administrator, or the Group, of any changes in the status of his or her Dependents, which affect their eligibility for coverage under the Program. These changes include a divorce or the marriage of a Dependent Child. If the Employee/Member does not notify the Plan Administrator, or the Group, of these types of changes and it is later determined that a Dependent was not eligible for coverage, the Plan Administrator has the right to retroactively terminate coverage and recover the full value of the services and benefits provided during the period of ineligibility. On behalf of the Group, CareFirst can recover these amounts from the Employee/Member or from the Dependent, at its option.

f. In the event of the death of the Employee/Member, coverage of enrolled Dependents will continue under the deceased Employee/Member's coverage until the last day of the month in which the death occurs. Thereafter, the surviving spouse or domestic partner and/or Dependent Children may be eligible for Continuation of coverage as explained in Section 3.6.

g. The Plan Administrator can terminate Employee/Member coverage and that of Dependents, with 31 days prior written notice, if it determines that:

- the Member allowed another person to use his or her identification card or used another person's card. If so, upon termination of coverage, the card must be returned to CareFirst upon request.
- the Member made an intentional misrepresentation of information to CareFirst, the Plan Administrator, or the Group, which is material to the acceptance of the Enrollment Application for that Member. Member's represent that all information contained in their Enrollment Applications is true, and complete to the best of their knowledge and belief.
- the Member or his or her representative made fraudulent misstatements related to coverage or benefits under this Program.

3.3 Reinstatement Requires Application. If coverage is canceled or terminated for any reason, coverage may be renewed only if the terminated Member reestablishes eligibility and submits an Enrollment Application in accordance with Section 2. Coverage will not reinstate automatically under any circumstances.

3.4 Effect of Termination. Except as provided in Section 3.5 below, no Program benefits will be provided for any medical services received on or after the date on which coverage under this Program terminates. This includes medical services received for an injury or illness that occurred before the effective date of termination. In addition, claims presented after the Program is terminated may be subject to certain time limitations as agreed to between CareFirst and the Group.

3.5 Extension of Benefits. Notwithstanding the termination rules in Sections 3.1 or 3.2, if an Employee/Member or his or her enrolled Dependent is confined in an institution on the date that the Program terminates, or coverage under the Program terminates, such confined Member will continue to receive the Program benefits described herein until the earliest of the following:

a. The date the confinement ceases; or

b. The date such Member is no longer, in the judgment of CareFirst's Medical Director, or his or her designee, medically required to continue care as an inpatient; or

c. The date such Member becomes covered under replacement coverage offered by the Group without limitation as to the condition for which the Member is an inpatient; or

d. 180 days following termination.

This Extension of Benefits under Section 3.5 will not be granted, however, if termination is due to failure to make a payment when otherwise required to do so.

3.6 Continuation of Coverage under COBRA. If this Program is sponsored by a Group that employs 20 or more people on 50 percent of the business days in the prior calendar year, then the benefits provided under this Program will be covered by the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). If COBRA applies, a Member may elect to continue coverage under the Program for at least 18 months, and up to 36 months. Members eligible for COBRA coverage are known as "Qualifying Beneficiaries," and events entitling a Member to continuation of coverage are known as "Qualifying Events." The Plan Administrator or his or her designee administers the COBRA rules.

Note: Domestic Partners and their dependents are <u>not</u> eligible for COBRA continuation coverage.

SECTION 4
CONVERSION PRIVILEGE

4.1 If the Employee/Member Is No Longer Eligible for Group Coverage. If coverage as an Employee/Member terminates because the Employee/Member is no longer an employee or member of the Group or no longer meets the eligibility requirements for Program benefits, the Employee/Member may purchase a Conversion Contract to cover that Employee/Member and his or her covered Dependents. Such person may choose to convert in lieu of, or at the conclusion of, the continuation coverage under Section 3.6, if applicable. **The Conversion Contract may not provide the same level of benefits as the Group Contract.**

4.2 Upon Employee/Member's Death. Following the death of an Employee/Member, the enrolled spouse or domestic partner or, if there is no spouse, the enrolled Dependent Children of the Employee/Member, may purchase a Conversion Contract.

4.3 Upon Termination of Marriage. If spouse's coverage under the Program terminates due to divorce or because the marriage is legally annulled, the spouse is entitled to purchase a Conversion Contract.

4.4 Upon Child's Ineligibility. If coverage of a Dependent child terminates because the child no longer meets the eligibility requirements of this Certificate (e.g., the child marries or attains the age limit) the child is entitled to purchase a Conversion Contract.

4.5 Upon Termination of the Group Contract by the Group. If coverage under the Program terminates because of the termination of the Contract by the Group, Members may purchase a Conversion Contract if the Group has not provided for continued coverage through another health plan or other group benefits program offered by or through the Group.

4.6 Upon Expiration of Continuation Coverage. Members may purchase a Conversion Contract upon expiration of continuation of coverage.

4.7 No Right to Conversion Contract. If coverage under this Program terminates for any other reason, a Member does **not** have the right to a Conversion Contract. These situations include:

a. Termination of coverage because the Member canceled Group Coverage or changed to another health benefits plan offered by the Group;

b. Loss of coverage by Dependents because the Employee/Member elected to change to a Self-Only or other non-Family Coverage or asked the Group to remove an eligible Dependent from coverage;

c. Termination of coverage due to nonpayment by or on behalf of the Member;

d. Termination of coverage for any of the reasons set forth in Section 3.2.g.

4.8 Application for Conversion Contracts. If an individual is eligible to purchase a Conversion Contract, CareFirst must receive the individual's application form, including full payment of the applicable premium, within 30 days after the effective date of termination. **Members should contact CareFirst's Customer Service Department, or the Plan Administrator, to learn of their rights and obligations in electing a Conversion Contract.** Conversion Contracts issued under this Section 4.8 will not require evidence of insurability. Benefits under Conversion Contracts may vary from the benefits under this Program and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract(s) it issues.

4.9 Effective Date of Conversion Contract. If a Member exercises his or her rights and purchases a Conversion Contract in accordance with this Section 4, the Conversion Contract will be effective on the day following the date the Contract terminated or the Member's coverage under this Program terminated.

SECTION 5
COORDINATION OF BENEFITS WITH OTHER PROGRAMS

5.1 Coordination of Benefits. This provision applies if a Member is covered both under this Program and by another Health Plan. The term "Health Plan" as used in this Section means this Program and (a) any other health maintenance organization contract or policy, or (b) any other health insurance contract or policy, regardless of whether issued on an individual or group basis and including a self-insured employer or union health plan or program, and which pays for health care services. The term "Health Plan" also includes a health insurance program sponsored by a state, municipal, or other governmental entity. Health Plan does not include any individual policy for contract for specified diseases or intensive care policy.

a. **Other Health Benefits.** When a Member is covered by two or more Health Plans and receives a service that is covered by this Program and by another Health Plan, the benefits under this Program will be coordinated with the other Health Plan. This prevents overpayment or duplicate payments for the same service. Under the rules to determine payment described below, the "Allowable Expense" for a covered service is determined first. Then a determination is made as to which Health Plan will be known as the "Primary Plan" and which Health Plan will be known as the "Secondary Plan." The portion of the Allowable Expense that each Health Plan pays or assumes is a function of whether the Health Plan is a Primary Plan or a Secondary Plan.

b. **Effect on Benefits.**

"Allowable Expenses" means any Plan Allowance, at least a portion of which is covered under at least one of the Member's Health Plans. When a Health Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be counted as an Allowable Expense.

The Program will coordinate benefits with the other Health Plan if the benefits under the Program, when added to the benefits of the other Health Plan, are greater than the Allowable Expenses. See Section 5.4 regarding a Member's cooperation in implementing this coordination arrangement.

If this Program is the Primary Health Plan, CareFirst will ignore the benefits provided by the Secondary Health Plan when determining benefits under this Program.

If this Program is the Secondary Health Plan, CareFirst will reduce the Allowable Expenses that this Program will cover by the amount of total Allowable Expenses that it is the responsibility of the Primary Health Plan to cover. In no event will the total benefits this Program provides exceed the total benefits that it would have provided if this Program were the Primary Health Plan.

5.2 Rules to Determine Payment. To determine which Health Plan is the Primary Health Plan, the following rules will be followed:

a, If the other Health Plan does not have a coordination provision, it will always be the Primary Health Plan.

b. If a Member is enrolled under one Health Plan as an Employee/Member or employee, and under the other Health Plan as a Dependent of an Employee/Member or employee, the Health Plan which covers the Member in the capacity as an Employee/Member or employee is the Primary Health Plan.

c. If a Member is enrolled as a Dependent by two different Health Plans--under one as a Dependent of one parent and under the other as a Dependent of the other parent--the Primary Health Plan will be the Health Plan of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year. (If both parents have the same date of birth, the Health Plan that has covered a parent for the longer period of time will be the Primary Health Plan.) This rule does not, however, apply if the other Health Plan follows a different rule to determine the Primary Health Plan. When this occurs, the Health Plan that has covered a parent for the longer period of time will be the Primary Health Plan. In addition, there are special rules for a child of separated or divorced parents.

If a court decree imposes financial responsibility for the health care expenses of the child on one of the parents, then the Health Plan of that parent is the Primary Health Plan. If there is no decree, the following rules apply:

- If the child is covered under one Health Plan through the parent with custody and under the other Health Plan through the parent without custody, the Health Plan of the parent with custody is the Primary Health Plan.
- If the parent with custody has remarried and the child is covered under three Health Plans: (a) the Health Plan of the parent without custody, (b) the Health Plan of the parent with custody, and (c) the Health Plan of the spouse (stepparent) of the parent with custody, the order of payment will be as follows: (1) the Health Plan of the parent with custody, (2) the Health Plan of the stepparent, and (3) the Health Plan of the parent without custody.

d. If none of the above apply, the Health Plan that has covered the Member for the longest period of time will be the Primary Health Plan. The start of a new Health Plan does not include:

- A change in the amount or scope of a Health Plan's benefits;
- A change in the entity paying, providing or administering Health Plan Benefits; or
- A change from one type of Health Plan to another (e.g., single employer to multiple or multi-employer plan).

e. Where two or more Secondary Health Plans remain, these rules to determine payment will be repeated until liability has been determined with respect to each remaining Health Plan.

The above rules apply whether or not the Member actually makes a claim for benefits under all the Health Plans to which the Member is covered.

5.3 Right to Receive and Release Information. In order to implement the Coordination of Benefits rules, CareFirst may request written consent and authorization to release medical records and related information. Upon receipt of such consent and authorization, CareFirst will have the right to release or obtain information necessary to process and coordinate claims. By enrolling in the Program, a Member agrees to furnish CareFirst with any reasonable information that it seeks to allow it to process claims and coordinate benefits. If a Member does not furnish it such information, it has the right to deny payments for the claim.

5.4 Recovery of Overpayment. If the Program mistakenly provides coverage in amounts greater than required by the rules set forth in the Program Description, CareFirst or the Plan Administrator will have the right to recover the overpayment from the Member or from any other person, insurance company, or organization that may have gained from the overpayment. Such recovery shall be payable over to the Group. The Member is required to do whatever is necessary to help CareFirst recover excess payments, including the completion and filing of claim forms with other organizations or insurance companies, or refunding to CareFirst or the Plan Administrator the amount of the mistaken payment.

5.5 Multiple Coverage through CareFirst. If a Member is covered under this Program and another group or individual health services contract that is issued by CareFirst or an affiliated entity, he or she will not be entitled to duplicate benefits or payments. If duplicate coverage occurs, CareFirst will provide benefits according to this provision up to the Allowable Expenses.

5.6 Medicare Eligibility. When benefits for covered services are paid by Medicare as primary, the Program will not duplicate those payments. When CareFirst coordinates benefits with Medicare, payments will be based on the Medicare Allowance (if the provider accepts Medicare assignment) or the Medicare Maximum Limiting Charge (if the provider does not accept assignment from Medicare).

5.7 Injuries or Illnesses Caused by Third Parties or in Certain Motor Vehicle or Other Accidents.

a. The rules set forth in this Section 5.7 apply to any illness or injury which is:

- Caused by an act or omission of a third party; or
- Covered under medical payment provisions of a liability or automobile policy issued to or otherwise covering the Member.

b. If a Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or care for which benefits were provided or will be provided under this Program, CareFirst may recover the amounts it pays or will pay, up to the sum received from or on behalf of the third party. CareFirst shall pay over that recovery to the Group. CareFirst will reduce the amount the Member owes the Program by the Program's pro-rata share of any attorneys' fees, court costs, or other costs the Member incurred in securing the payment. The pro-rata share will be equal to the Member's total costs multiplied by the ratio of (1) the total medical expense accounted for in the lawsuit or claim, and (2) the total amount recovered. The Member will not be responsible for any portion of attorneys' fees, court costs, or any other costs, which are directly related to the amount CareFirst recovers.

c. By participation in the Program and in consideration for the benefits the Program provides, a Member shall agree to grant CareFirst and the Group a lien on all funds the Member recovers up to the total amount of benefits provided by the Program. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss.

d. By participation in the Program and in consideration for the benefits the Program provides, a Member shall agree to grant CareFirst the option to be subrogated to the Member's rights to the extent of the benefits provided under this Program. This includes CareFirst's right to bring suit or file claims against the third party in the Member's name.

e. The Member agrees to take actions, furnish information and assistance, and execute such instruments as CareFirst may require to enforce rights under this Section. The Member agrees not to take any action which prejudices the Program's rights and interests under this provision. If the Member does not cooperate in CareFirst's administration of this provision, the Program will **not** provide coverage for the illness or injury. In addition, the Member will be responsible for any legal expenses CareFirst incurs to enforce rights under this Section.

5.8 Employer or Governmental Benefits. The Program will not cover the cost of services nor will it pay for services for any illness, injury, or condition that would otherwise be covered if the Member will receive coverage from one of the following:

a. any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

b. any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, but excluding Medicare benefits (See Section 5.6, above) and Medicaid benefits.

SECTION 6
CUSTOMER SATISFACTION AND APPEAL PROCEDURE

The Customer Satisfaction and Appeal Procedure is designed by CareFirst BlueCross BlueShield (hereafter the "Plan") to assure that Member concerns are fairly and promptly heard and resolved. By following the steps outlined below, Member concerns can be quickly and responsively addressed.

6.1 Step I: Inquiry/Discussion of the Problem Often, Member concerns can be most effectively handled and resolved through informal discussions and information gathering. If the Member's question concerns our handling of a claim or other administrative action, the Member or Member's representative should discuss the matter with our Member and Provider Services Department which can contact the appropriate individuals and gather information to answer the question. In many instances, the matter can be quickly resolved.

6.2 Step II: Request for Reconsideration (Initial Appeal) If the Member's question or problem could not be satisfactorily resolved during the discussion of the problem, the Member or Member's representative may make a Request for Reconsideration. This request should be in writing, addressed to our Member and Provider Services Department and shall state the reason(s) for the request. If for some reason, the Member or Member's representative can not put the request in writing, please contact our Member and Provider Services Department for assistance. This request must be made within six (6) months from the date of the denial of benefits. A decision by the Plan shall be made within forty-five (45) calendar days of receipt of the initial appeal. If a decision can not be made within this timeframe, the member will be notified and a decision shall be made within 21 additional working days.

An expedited appeal process for medical necessity issues has been established in the event that a delay in a decision would be detrimental to the health of the Member. In an expedited appeal, a decision by the Plan shall be made within twenty-four hours of receipt and review would be performed by a peer of the Member's treating healthcare provider.

In many instances, the Request for Reconsideration shall be reviewed by a peer of the Member's treating healthcare provider. The Member or Member's representative can seek a Request for Reconsideration only if the initial decision causes or may cause financial liability to that Member.

6.3 Step III: Grievance and Appeal Committee Review (Final Internal Appeal) If the Member is still dissatisfied with the outcome of the Reconsideration, the Member may make a request for review by the Grievance and Appeal Committee. The request should be in writing, addressed to our Appeals Management and Analysis Section and shall state the reason(s) for the request. This request must be made within sixty (60) days from the date of the Reconsideration determination. The Member has the right to appear before the Grievance and Appeal Committee. A decision by the Grievance and Appeal Committee shall be made within 30 business days after the request has been received.

6.4 Step IV: Complaints concerning CareFirst BlueCross BlueShield If the Member has complaints regarding the operation of CareFirst BlueCross BlueShield or regarding the quality of care or quality of service rendered by a provider, the Member is encouraged to notify the Quality Management Department of CareFirst BlueCross BlueShield at the address listed below.

CareFirst BlueCross BlueShield
Quality Management Department
550 12th Street, SW
Washington, DC 20065
202-479-8000

SECTION 7
GENERAL PROVISIONS

7.1 No Assignment. A Member cannot assign any benefits or payments due under this Program to any person (including a physician), corporation or other organization. Any assignment by the Member will be void.

7.2 Payments Under the Program. Payments for covered services rendered by Participating Providers (as defined in Attachment A) will be made directly to them or to their representatives. If a Member receives covered services from any other provider, CareFirst reserves the right to pay either the Member or the provider. In addition, if a Member is covered as a Dependent Child under a court or administrative order and a parent, who is not the Employee/Member, incurs covered expenses on the Member's behalf, CareFirst reserves the right to make payment for these covered expenses to the non-Employee/Member parent or the provider. Payment will, in either case, be full and complete satisfaction of benefit and payment obligations under this Program.

7.3 Claim Payments Made in Error. If CareFirst makes a claim payment to a Member or on a Member's behalf in error, the Member will be required to repay the Program the amount that was paid in error. If the Member has not repaid the full amount owed the Program and CareFirst makes a subsequent benefit payment, it may subtract the amount owed from the subsequent payment.

7.4 Time Period for Filing Claims. All claims for covered services and supplies must be submitted to CareFirst within 15 months after the date the services were rendered or the supplies were received. CareFirst will consider claims beyond the 15-month claims filing period if the Member becomes legally incapacitated prior to the end of the filing period, or for other good cause shown.

7.5 Provider and Services Information. Listings of current Participating Providers will be made available to Members at the time of enrollment. Updated listings are available to the Group or Members upon request. The listing should be requested from the Customer Service Representative.

7.6 Events Outside CareFirst's Control.

a. For purposes of this Section, an event "outside the control of the Program" refers to a natural disaster, epidemic, complete or partial destruction of facilities, disability of a significant part of the Program or Provider staff, war, riot, civil insurrection or any similar event over which the Program cannot exercise influence or control.

b. When an event outside the control of the Program affects the operations of the Program or Providers, CareFirst will use its best efforts to continue to provide and arrange benefits and services to Members, taking into account the impact of the event on facilities and personnel and the extent to which the services required by the Member are medically necessary and urgently needed.

c. If CareFirst is unable to provide or arrange benefits under Section 7.6.b from Participating Providers, the Program will cover services obtained from **any** physician, hospital or provider of the Member's choice as if it had been provided by such Participating Provider, but only if and to the extent CareFirst determines:

- That the services would have been covered under the Program if provided or arranged by a Participating Provider;
- That obtaining these services from Participating Providers was impossible, impractical or would have entailed a medically unacceptable delay; and
- That the services were medically necessary and urgently needed.

d. Except as provided in paragraphs "b" and "c" above, neither the CareFirst nor any Participating Provider will have any liability or obligation for delay or failure to provide or arrange any services or benefits when the delay or failure is caused by an event outside the Program's control.

7.7 Entire Contract. The Contract entered into between CareFirst and the Group, including the Employee/Member's Enrollment Application, this Program Description, the Summary Plan Description, and any Amendment attached to the Contract, this Program Description, or the Summary Plan Description constitutes the entire Contract setting forth this Program. No change in the Contract will be valid unless it is first approved by an officer of CareFirst or his or her designee and issued as an Amendment to the Contract.

7.8 Incontestability. Except in the instance of fraud, all statements made by a Member or the Group will be considered representations and not warranties and no such statement will be the basis for withholding coverage or denying a claim after coverage has been in force for two years from its effective date.

7.9 Legal Actions. Any lawsuit by a Member against CareFirst, the Group, the Program, or the Plan Administrator under the Contract, including this Program Description, must be commenced within two years from the date the Member received the service for which, or on account of which, payment is being sought. In addition, before a Member may bring a lawsuit, the Member must first submit a claim to CareFirst and follow the Customer Satisfaction and Appeal procedures described in Section 6. The requirement to submit a claim before bringing a lawsuit does not apply if the lawsuit is commenced within the 60 day period immediately preceding the end of the two year period described above.

7.10 Identification Card. Any cards CareFirst issues to a Member under this Program are for identification only. Possession of an identification card confers no right to benefits under this Program. To be entitled to such benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable amounts under this Program have actually been paid. Any person receiving benefits to which he or she is not then entitled under the provisions of this Program will be liable for the actual cost of such benefits.

7.11 Member Medical Records. It may be necessary to review and/or obtain medical records and information from hospitals, skilled nursing facilities, physicians or other providers who treat a Member. When a Member becomes enrolled under this Program, he or she (or, if legally incapable of giving such consent, his or her representative) automatically gives CareFirst permission to obtain and use such records and information, including - without limitation -medical records and information requested to assist CareFirst in determining benefits and eligibility. If a Member elects not to consent to the release of medical records, CareFirst may be unable to administer coverage and process claims for payment, and it will have the right to deny payment of such claims.

7.12 Confidentiality. Patient-identifying information from Member medical records and patient-identifying information received by providers incident to the provider-patient relationship will be kept confidential and will not be disclosed to any other person without prior written consent of the Member, except for internal use by CareFirst in the administration of the Program, or to comply with government requirements established by law.

7.13 Relationship to Providers. Providers, including Participating Providers, are independent contractors and are related to CareFirst by contract only. Providers are not employees nor agents of CareFirst and are not authorized to act on behalf of, or obligate CareFirst with regard to, interpretation of the terms of the Contract or Program, including eligibility of Members for coverage or entitlement to benefits. Providers maintain a physician-patient relationship with the Member and they, not CareFirst, not the Group, and not the Plan Administrator, are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death, of Providers, or any other individual, facility or institution that provides services to Members or any employee, agent or representative of such Providers. The ultimate decision whether to obtain care from a Provider is made by the Member.

7.14 CareFirst's Relationship to the Group. The Group is not an agent or representative of CareFirst or any provider. CareFirst is not liable for any acts or omissions of the Group.

7.15 Administration of Contract. CareFirst has complete discretionary authority to adopt reasonable policies, procedures, rules and Program interpretations to promote the orderly and efficient administration of the Contract. Such authority includes the authority to decide claims, subject to review by the Plan Administrator, as provided for in Section 6 (Customer Satisfaction and Appeal Procedure).

7.16 Contract Binding on Members. The Contract can be amended, modified or terminated in accordance with any provision of the Contract or by mutual agreement between CareFirst and the Group, without the consent or concurrence of Members. By electing coverage under this Program, or accepting benefits under this Program, Members are subject to all terms, conditions and provisions of the Contract.

7.17 Program Not Modified by Oral Statements. Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations, and/or exclusions of this Program Description, the Contract, or the Program itself, or increase or void any coverage or reduce any benefits under the Program. Such oral statements cannot be used in the prosecution or defense of a claim under this Program.

7.18 Reliance Upon Oral Communications. In consideration of the benefits received under the Program and as an obligation of membership in this Program, each Member agrees that he or she will not rely upon any oral communication from CareFirst about the terms of the Program.

7.19 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under the Group Contract:

a. All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

b. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

c. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

d. "Day" means a calendar day, including weekends, holidays, etc., unless a different basis is specifically stated.

e. "Year" refers to calendar year, unless a different basis is specifically stated.

7.20 Notices. Whenever the terms of the Contract or this Program Description require a Member, CareFirst or the Group to "give notice" or "notify" another party, the following requirements apply:

a. **To the Member.** Notices to Members will be sent by mail to the most recent address for the Member in the Program's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

b. **To CareFirst.** When notice or payment is sent to CareFirst, it must be sent by first class mail to:

Group Hospitalization and Medical Services, Inc.
550 12th Street, S W
Washington, DC 20065

Notice will be effective on the date of receipt by CareFirst, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service. CareFirst may change the address at which notice is to be given by giving written notice to the Group.

c. **To the Group.** Notices to the Group will be sent by confirmed facsimile, or guaranteed overnight mail, with tracing capability, or by first class mail to the address set forth in the Contract. Notice will be effective on the date of receipt by the Group, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

7.21 Contract Solely Between the Group and the Plan. The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Group and the Plan; that the Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting the Plan to use the Blue Cross and Blue Shield Service Marks in the District of Columbia and portions of Maryland and Virginia; and that the Plan is not contracting as the agent of the Association. The Group, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Plan; and no person, entity, or organization other than the Plan shall be held accountable or liable to the Group for any of the Plan's obligations to the Group created under this Contract. This paragraph shall not create any additional

obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this Contract.

7.22 Rights Under Federal Laws. The Group may be subject to federal law (including the Employee Retirement Income Security Act of 1974, as amended ["ERISA"], the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ["COBRA"], and/or the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) that relates to the health benefits Members are provided under this Contract. In that case, the Group (or its designee) is the "Plan Administrator" and named fiduciary for purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's (or its designee's) responsibility to provide a Member with certain information, including access to, and copies of, plan documents describing benefits and rights to coverage under the group health plan. Such rights may include the right to continue coverage upon the occurrence of certain "qualifying events". If CareFirst is designated by the Group as the Plan Administrator, CareFirst may designate persons other than itself to carry out its Plan Administrator responsibilities, including Plan Administration responsibilities under COBRA. Whenever CareFirst designates persons to carry out discretionary acts in plan administration, as set forth above, CareFirst shall be considered a named fiduciary under ERISA in performing such designations.

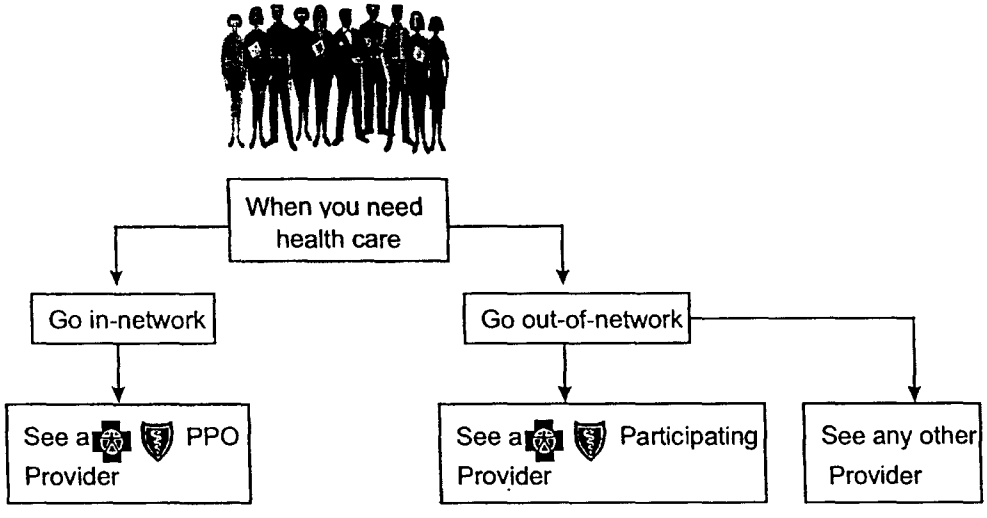
HIGHLIGHTS OF THE PREFERRED PROVIDER OPTION (PPO)

- The PPO covers most of your health care needs and enables you to choose where to receive services:
  - In-network, from a Preferred Provider
  - Out-of-network, from any other provider that Blue Cross and Blue Shield recognizes as an eligible covered provider of medical services
- When you receive services in-network, your Preferred Provider will coordinate your care, obtain any required authorizations and submit claims for you. You will receive a higher level of benefits, and your out-of-pocket expense is less.
- When you receive services out-of-network, you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement. Your level of benefits will be lower than if you receive services in-network, and your out-of-the-pocket expense is higher.
- Covered services include:
  - physician office visits
  - laboratory tests and X-rays
  - preventive care
  - inpatient and outpatient hospital services
  - mental health and substance abuse services

HOW THE PPO PROGRAM WORKS

In-Network vs. Out-of-Network Coverage

You have selected coverage under the Preferred Provider Plan. With this program, you can decide how to receive care every time you need health care services — in-network or out-of-network.



In-network coverage

When you need in-network care, you see one of the plan's Preferred Providers. A Preferred Provider is a licensed doctor/practitioner or facility/hospital invited to join CareFirst BlueCross BlueShield's network after a careful screening of credentials. Preferred Providers agree to deliver services covered by the program to members at a fixed cost. By using an in-network provider, you will receive a higher level of benefits, your out-of-pocket expense is less, and you will not have to fill out any claim forms. Your provider will obtain any authorization you may need.

Out-of-network coverage

When you choose out-of-network coverage, you can see any covered provider, but you will receive a lower level of benefits. If you go to an out-of-network provider, there are two types of providers you can use — a BlueCross BlueShield Participating Provider and a Non-Participating Provider. If you see a Participating Provider, the program will pay the provider directly, and there are no claim forms for you to fill out. You will need to obtain any authorization required (see page 37). If there is any difference between what the Participating Provider actually charges for a service and what the plan allows, you will not be responsible for paying that difference. You will be responsible for any coinsurance and deductible that may apply.

If you see a Non-Participating Provider, you may have to pay for your services up-front and submit a claim form for reimbursement up to the plan allowance, less any coinsurance and deductible that may apply. In addition, you will be responsible for the difference (if any), between the actual charge for a service and what the plan allows. You will need to obtain any authorization required. (For more information on how to submit a claim, see page 32.)

The Choice Is Yours

The following table shows the steps involved when you choose to go in-network (see a Preferred Provider) or out-of-network (see a BlueCross BlueShield Participating or Non-Participating Provider) for medical care.

<table>
<tr><td>In-Network</td><td>If you see a Preferred Provider
You pay a small copayment or coinsurance (usually after your annual deductible has been met)
You file no claims</td><td>If you need hospitalization, home health care or hospice services
Your doctor will obtain necessary approval and arrange services
You file no claims</td></tr>
<tr><td rowspan="2">Out-of-Network</td><td>If you see a Participating Provider
After you meet your annual deductible, the plan pays out-of-network benefits directly to the doctor
You pay a coinsurance (usually after the deductible has been met)
You file no claims</td><td>If you see a Non-Participating Provider
You may need to pay the full amount of services at the time the services are rendered
You will file a claim and, after you have met your annual deductible, receive reimbursement of plan allowance for services</td></tr>
<tr><td colspan="2">If you need hospitalization, home health care or hospice services:</td></tr>
<tr><td></td><td>If you see a Participating Provider
You call the Utilization Management section of CareFirst BlueCross BlueShield for approval of services
You pay a coinsurance (usually after the deductible has been met)
You file no claim forms</td><td>If you see a Non-Participating Provider
You call the Utilization Management section of CareFirst BlueCross BlueShield for approval of services
You pay your bills at the time of service, or authorize your provider to file a claim
You may be responsible for paying any expenses not covered by the plan
You file claim forms</td></tr>
</table>

Out-of-Pocket Costs

Your out-of-pocket costs will depend on the type of provider you or your family members see when you need care:

- Preferred Provider (*in-network*)
- Participating Provider (*out-of-network*)
- Any other covered provider (*out-of-network*)

Annual deductible

For most in-network services and all out-of-network services, you must first meet an annual deductible before the program will begin to provide benefits. Your deductible will depend on the level of coverage you have selected and whether services are rendered in or out of network. The following deductibles will apply:

	In-Network and Out-of-Network
Individual coverage	$125
Family coverage	$325

If you have family coverage, the family deductible can be met by any number of covered dependents. However, one covered dependent may not contribute more than the individual deductible toward the family limit. Once the family deductible is met, the deductible for all covered dependents will be satisfied.

After you meet the deductible, you will also be responsible for coinsurance (see below).

These additional out-of-pocket costs will depend on whether services are rendered in-network or out-of-network.

Coinsurance

For all out-of-network and some in-network services, you are responsible for a percentage of the cost of services you receive, called coinsurance.

Preferred Providers have agreed to accept a fixed amount for each service offered by the program, called the preferred provider allowance. For some in-network services, you will pay a percentage of the preferred provider allowance.

If you go out-of-network to a Non-Participating Provider, the plan will pay a percentage of the cost for covered services, up to the plan allowance. If your Non-Participating Provider charges more than the plan allowance, you will be responsible for paying your percentage of the plan allowance in addition to any charges above the allowance. This additional amount is *not* counted toward your deductible or the annual out-of-pocket maximum. Check the Benefits Schedule for your coinsurance for specific services.

Following are three examples that illustrate how to determine your out-of-pocket costs.

Example 1 — Let's assume:

1. You have family coverage
2. Your child is sick and needs to see a doctor
3. You choose to see a Participating Provider (out-of-network coverage)
4. The cost of the office visit is $70, and the plan allowance for an office visit is $50
5. You have already met your family deductible

Here's how you would calculate your out-of-pocket costs.

The plan pays	$40 (80% of $50)
You pay	**$10**

**You are not responsible for the difference ($20) between actual charges ($70) and the plan allowance ($50).*

Example 2 — Let's make the assumptions used in the above example, but use a Non-Participating Provider instead.

1. You have family coverage
2. Your child is sick and needs to see a doctor
3. You choose to see a Non-Participating Provider (out-of-network coverage)
4. The cost of the office visit is $70, and the plan allowance for an office visit is $50
5. You have already met your family deductible

Here's how you would calculate your out-of-pocket costs.

The plan pays	$40 (80% of $50)
You pay	**$30** (The $20 that your doctor charges over the plan allowance and 20% coinsurance.)

Out-of-pocket maximum

To protect you and your family from the cost of a catastrophic illness or accident, there is a limit on the amount of out-of-pocket medical expenses you will be expected to incur for covered services every calendar year. This is called the out-of-pocket **maximum**. After your costs reach the maximum, the plan will pay 100% of your covered medical costs. The following out-of-pocket maximums will apply:

	In-Network and Out-of-Network
Individual coverage	$1,500
Family coverage	$3,000

If you use a combination of in- and out-of-network services, the amount of money spent for each type of service can be combined to meet your out-of-pocket maximum.

If you have family coverage, eligible expenses of all covered members can be combined to meet your family out-of-pocket limit. However, one covered dependent cannot contribute more than the individual limit toward meeting the family limit.

Lifetime maximum

The PPO also has an individual lifetime maximum. Once you have met the

lifetime maximum, your benefits will be limited. The individual lifetime maximum is $1,000,000 and any further coverage will be limited to $2,500 per calendar year.

Filing a Claim

If you see a Non-Participating Provider, you are responsible for filing a claim form, or for ensuring that your doctor's office or hospital files one for you. As previously discussed, if you see a Preferred Provider or Participating Provider, you will not need to file a claim.

Claim forms are available from your employer, the Group Administrator or by calling CareFirst BlueCross BlueShield Member Services at 202-479-6099 or 800-424-7474, Ext. 6099. Attach an itemized bill to your completed claim form and submit it to:

CareFirst BlueCross BlueShield
550 12th Street, SW
Washington, DC 20065

Claims must be submitted to CareFirst BlueCross BlueShield within 12 months of the date the services or supplies were received. CareFirst BlueCross BlueShield will only consider claims beyond the 12-month filing limit if you are legally incapacitated.

You should keep copies of all bills for your records. Your original bills will not be returned.

COMMONLY ASKED QUESTIONS AND ANSWERS ABOUT YOUR PPO PROGRAM

Q.	**My family and I are planning to vacation in another state. What should we do if we need a doctor or hospital while we are gone?**
A.	When you enrolled in the Preferred Provider Option, you were automatically enrolled in the *BlueCard PPO Program*. With this program, you can see any Blue Cross and Blue Shield Preferred Provider and receive the same level of coverage as if you saw a Preferred Provider at home. To receive care when you are away from home, call 800-810-BLUE for information on the nearest Preferred Provider doctors and hospitals. The doctor you see will submit claim forms for you but you will be responsible for obtaining authorization for specialty services (utilization management).

Q.	**My daughter is going away to college next year. Will she still be covered under my plan?**
A.	Yes. Your children will be covered up to age 25 as long as they are full-time students, or meet the eligibility requirements of a dependent child. Complete a student certification form, available from the Group Administrator.

Q.	**How do I know when I have to obtain special authorization to receive coverage?**
A.	You must get pre-authorization from the Utilization Management department if you need inpatient admissions to a hospital or skilled nursing facility, home health care, or hospice services. If you receive in-network services, you or your doctor will arrange for pre-authorization. If you go out-of-network, you are responsible for calling Utilization Management at 202-479-6718 or toll-free at 800-553-8700 and arranging your care.

Q.	**I am going to be in my home country for four weeks next spring. Will I be covered by Blue Cross Blue Shield's PPO there?**
A.	As a Blue Cross Blue Shield PPO member traveling abroad, you will receive benefits as if you were under the out-of-network portion of your Plan. You will need to pay the bill in full and submit it with the Medical Claim Form to Blue Cross Blue Shield when you return to the Washington, DC metropolitan area. These benefits are provided through BlueCard Worldwide, an extension of the domestic Blue Cross and Blue Shield provider networks. BlueCard Worldwide allows members to receive covered inpatient health care from participating hospitals in countries around the world when traveling abroad. Blue Cross and Blue Shield members will pay nothing more than the out-of-pocket expenses that they pay domestically (non-covered services, deductibles, copays and coinsurance). The BlueCard Worldwide network is available to all Blue Cross and Blue Shield members whose claims are eligible for processing through the BlueCard Program.

Other Questions?

If you have questions about CareFirst BlueCross BlueShield, your options, covered services, your level of coverage, claims or any other aspect of your plan, call CareFirst BlueCross BlueShield at:

202-479-6099
or toll-free at
800-424-7474, Ext. 6099

DESCRIPTION OF COVERED SERVICES

ATTACHMENT A
PPO PROGRAM OPTION

This Attachment A describes the medical services eligible for coverage under the PPO Program Option. The amount that the Program pays for these covered services is set forth in the Benefits Schedule (Section 12). The Benefits Schedule also lists important information about Member Deductibles, Out-of-Pocket Limits, the Lifetime Maximums and other features that affect the cost of coverage.

SECTION 1
GENERAL PROVISIONS

1.1 Coverage under the PPO Program. The PPO Program offers two levels of benefits. Members may select the benefit level at which coverage will be provided each time care is sought. Under the PPO Program, Members may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. A Member may not receive duplicate benefits for the same services.

1.2 In-Network Option. When In-Network coverage applies, Members are eligible for a higher level of benefits than the Out-of-Network benefits. In-Network benefits apply in the following instances:

a. **Services Rendered By a Preferred Provider.** When Members use a Preferred Provider, benefits are based on the appropriate Preferred Provider Allowance. The level of benefits is reflected in the Schedule of Benefits (Section 12). Preferred Providers will submit claims to CareFirst directly for covered services. The Preferred Provider will accept 100% of the Preferred Provider Allowance as full payment for covered services.

b. **Accidental Injury or Medical Emergency.** Coverage will be provided under the In-Network Option if the Member receives covered Emergency Services, as defined in section 4.4 below from a provider who is not a Preferred Provider. In this instance, benefits will be based on the appropriate Program Allowance for the service or supply provided. The level of benefits (i.e., coinsurance) for these Providers' services will be those shown under In-Network Option in Section 12. Members may be responsible for amounts in excess of the Program Allowance.

1.3 Out-of-Network Option. Coverage under the Out-of-Network Option applies if the Member obtains covered services from a Provider who is not a Preferred Provider in a circumstance not addressed in section 1.2.b. above. When the Out-of-Network Option applies, Members will receive reduced benefits for covered services. When Members use a provider that is not a Preferred Provider, payment is based on the appropriate Program Allowance. The level of Out-of-Network benefits is shown in Section 12. Members may be responsible for amounts in excess of the Program Allowance for these services.

1.4 Overview of Cost Sharing and Maximum Amounts. This section summarizes the basic rules governing for what a Member pays and what the Program pays for covered services. Detailed information about these payment features can be found in Section 12, Benefits Schedule, including specific terms and amounts and any special exceptions.

Deductible:	For most covered services, the Program does not begin to pay benefits until a Member meets his or her deductible for that year. The deductible will be calculated on a calendar year basis. Under the Preferred Provider Plan, there may be a single deductible for In-Network and Out-of-Network services or separate deductibles that apply to each. This is explained in the Benefits Schedule (Section 12). Until the deductible is satisfied, when a Member receives services subject to the deductible he or she must pay for them directly. Once a Member has satisfied the deductible, the Program will pay for covered services, less coinsurance, and copayments. The Benefits Schedule provides additional information about the deductible(s), including the amount of the deductible(s), how the deductible(s) apply to In-Network and Out-of-Network services and a listing of the services that are subject to the deductible(s).
Coinsurance	Once the deductible is met (or for services that are not subject to the deductible), benefits are based on a sharing of costs between the Member and the Program. For most covered services, these costs are shared based on the percentage of the cost that the Program pays and the percentage that the Member must pay. These percentages are referred to as the coinsurance.

Annual Out-of-Pocket Limit	This feature limits the maximum amount that a Member will have to pay in coinsurance in any given year. Under the Preferred Provider Plan, there may be a single out-of-pocket maximum for In-Network and Out-of-Network services or separate out-of-pocket maximums that apply to each. This is explained in the Benefits Schedule (Section 12). Once a Member meets the annual Out-of-Pocket Limit, he or she will no longer be required to pay a share of the coinsurance for the remainder of that year.
Lifetime Maximum	There is a cap on the total benefits that the Program will pay on behalf of any individual Member in his or her lifetime. A Member who reaches the lifetime maximum will thereafter have only a limited benefit, up to an "Annual Benefit Restoration Amount." These terms are further described in the Benefits Schedule.

1.5 Benefit Terms Defined. In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used:

a. **Eligible Provider** means either a Health Care Facility or a Health Care Practitioner, as these terms are defined below, licensed or otherwise authorized by law to provide health care services.

- **Health Care Facility** means a hospital, ambulatory surgical facility or center, inpatient rehabilitation facility, home health agency, skilled nursing facility, hospice facility, hospice program or partial hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.
- **Health Care Practitioner** means a physician, dentist (D.D.S. or D.M.D.) or other provider of health care services, such as: a chiropodist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physician assistant, physiotherapist, audiologist, licensed homeopathic practitioner, acupuncturist, Christian Science practitioner, psychologist and social worker.

b. **Participating Provider** means an Eligible Provider that contracts with CareFirst to be paid directly for rendering covered services to eligible Members of this Program.

c. **Preferred Provider** means a Preferred Facility or a Preferred Practitioner, as defined below.

- **Preferred Facility** means a Participating Provider that is a facility and which has a written agreement with CareFirst to render covered services to eligible Members of the PPO Program. The fact that a facility is a Participating Provider does not guarantee that the facility is a Preferred Facility.
- **Preferred Practitioner** means a Participating Provider who is a licensed Health Care Practitioner and who has a written agreement with CareFirst to render covered services to eligible Members of the PPO Program. The fact that a Health Care Practitioner is a Participating Provider does not guarantee that the Health Care Practitioner is a Preferred Practitioner.

A listing of Preferred Providers will be provided to Members when they enroll and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

1.6 Limitation on Provider Coverage. Services are covered only if the provider is an Eligible Provider as defined above, is licensed in the jurisdiction in which the services are rendered and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to a Member by any individual who:

a. is not an Eligible Provider, as defined above;

b. is the Member's spouse, mother, father, grandparent, daughter, son, brother, or sister; or

c. resides in the Member's home.

1.7 Program Benefit Payments. Except when a Member receives services under the BlueCard Program as described below, CareFirst will make payments based on the Program Allowance for the particular service and provider.

a. **Preferred Providers**. For services and supplies provided by Preferred Providers, payments are based on Preferred Provider Allowances. Preferred Provider Allowances are generally the contracted rates or fee schedules that Preferred Providers have agreed to accept from the Plan as payment under the PPO Program. In certain cases, however, Preferred Provider Allowances may be established by law.

b. **Participating Providers**. For services and supplies provided by Participating Providers, the Program Allowance is based either on Preferred Provider Allowances or Participating Provider Allowances. Section 12, Schedule of Benefits, sets forth the basis on which such benefit payments are based under this Program. Participating Provider Allowances are generally the contracted rates or fee schedules that Participating Providers have agreed to accept from the Plan as payment under this program. In certain cases, however, Participating Provider Allowances may be established by law. Participating Providers are not required to accept Preferred Provider Allowances as full payment. In the event that benefit payments are based on Preferred Provider Allowances, Participating Providers may bill the Member for the difference between the Preferred Provider Allowance and the Participating Provider Allowance.

c. **Non-Participating Providers**. When a Member uses an Eligible Provider that is not a Participating Provider, (a "Non-Participating Provider") the Program payment is based on the lower of the provider's usual customary rate charged or the established Program Allowance, if one has been established for that type of Eligible Provider and service. Program Allowances are based either on Preferred Provider Allowances or Participating Provider Allowances. Section 12, Schedule of Benefits, sets forth the basis on which such benefit payments are based for the Member's coverage. Non-Participating Providers are **not** required to accept the Program Allowance as full payment, and as a result may bill the Member for any balance **above** the Program Allowance.

In any event, Members will be responsible for applicable deductibles, coinsurance and copayments as set out in Section 12, Schedule of Benefits, and Preferred, Participating and Non-Participating Providers may bill the member directly for such amounts.

1.8 BlueCard Program. The independent Blue Cross and Blue Shield licensees throughout the country are working together in a new cooperative arrangement called the BlueCard Program. Under this program, if the Member receives services outside the CareFirst service area from a health care provider that participates with another Blue Cross and/or Blue Shield licensee ("Host Plan"), the Member is responsible only for the coinsurance, copayment, and/or deductible. The calculation of the Member's liability for covered services for claims incurred will be processed through the BlueCard Program. The Member's coinsurance, copayment, and/or deductible payments will be based on the lower of the provider's billed charges or the negotiated rate that CareFirst pays the Host Plan.

The negotiated rate paid by CareFirst to the Host plan for health care services provided through the BlueCard Program will represent one of the following:

- the actual price paid on the claim; or
- an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with all of the host plan's health care providers OR one or more particular providers; or
- a discount from billed charges representing the Host plan's expected average savings for all of its providers or for a specified group of providers.

Host Plans using either the estimated price or average savings factor may prospectively adjust the estimated or average price to correct for overestimated or underestimated past prices.

In addition, in a small number of states, statutes require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Member's liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. Therefore, when this payment method results in a conflict of statutes or regulations between two states, CareFirst is obligated to comply with the statutes of the jurisdiction in which this Agreement was issued.

1.9 BlueCard PPO. When Members receive treatment under the BlueCard Program described above, they may take advantage of the "Host" Plan's preferred provider network. If a Member receives care from a preferred provider of the Host Plan, the member will receive benefits at the "In-Network" level. If the Member chooses not to see a preferred provider from the Host Plan, when one was available to him or her, benefits will be administered at the "Out-of-Network" level.

To receive "In-Network" benefits through BlueCard PPO Program, Members should follow the steps outlined below:

a. Members should call the BlueCard PPO number, 1-800-810-BLUE (2583), to obtain names of preferred providers in that area. (This phone number is also printed on Member identification cards.)

b. Members should present their identification card with the PPO Logo to the preferred provider.

c. The preferred provider will render the service and submit the claim to the Host Plan. The claim will then be processed through the BlueCard Program described above.

d. Members are responsible for obtaining authorization for the following service(s):

- Hospitalization

Failure to receive authorization and to comply with the Utilization Management Requirements may result in penalties. Members should consult the Benefits Schedule, Section 12, for more information.

SECTION 2
UTILIZATION MANAGEMENT REQUIREMENTS

IMPORTANT

FAILURE TO MEET THE REQUIREMENTS OF THE UTILIZATION MANAGEMENT PROGRAM MAY RESULT IN A REDUCTION OR DENIAL OF COVERAGE EVEN IF THE SERVICES ARE OTHERWISE MEDICALLY NECESSARY.

2.1 Utilization Management. Before certain services will be covered, they will be subject to review and approval under utilization management requirements established by the Program. Through utilization management, CareFirst reviews a Member's care and evaluates requests for approval of coverage in order to assess the medical necessity for the services, the appropriateness of the hospital or facility requested, and the appropriate length of confinement or course of treatment. This assessment will be made in accordance with established criteria. In addition, utilization management may include second surgical opinion and/or preadmission testing requirements, concurrent review, discharge planning and case management. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures will result in the denial of or a significant reduction in benefits. The effect on coverage for failure to comply with utilization management requirements is explained in Section 12. If coverage is reduced or denied for failure to comply with utilization management requirements, the reduction or exclusion will be applied to all services related to the treatment, admission or portion of the admission for which utilization management requirements were not met.

2.2 Preferred Provider Responsibility. Preferred Providers are responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf for certain types of services and/or episodes of care. These are designated in the Schedule of Benefits. For these services., Members will not be responsible for notification and approvals. However, the Member must advise the Preferred Provider that he or she is eligible under the PPO Program. In addition, Members must comply with utilization management requirements and determinations. If the Member refuses to follow these requirements, coverage will be reduced or excluded. **In all other instances, it is the Member's responsibility to comply with the utilization management requirements described in section 2.5, below.**

2.3 Member Responsibility. Except as provided in Section 2.2, above, Members are responsible for all Utilization Management Requirements. It is the Member's responsibility to assure that hospitals, physicians and other providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst's inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in its offices. If CareFirst is unable to conduct utilization reviews, benefits may be reduced or denied.

2.4 Procedures. To initiate Utilization Management review, a Member may directly contact CareFirst or may arrange to have notification given by a family member or by the physician, provider, or facility that is involved in the Member's care. These individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required or provide inaccurate or incomplete information, the Member will be responsible for any reduction or exclusion of benefits.

CareFirst will provide additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment at any time upon the Member's request. For questions regarding utilization management requirements, Members should call the toll free number for precertification on the back of their ID card.

2.5 Services Subject to Utilization Management. Except as provided in section 2.2, above the Member **must** satisfy the utilization management requirements to qualify for coverage for the following services:

a. **Hospital Inpatient Services. All** hospitalizations (including maternity) require precertification. A Member must contact CareFirst (or have his or her physician or the hospital contact us) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five business days due to medical condition, CareFirst must receive notification of the admission as soon as possible but in any event within 48 hours following the beginning of the admission or the end of the first business day following the beginning of the admission, whichever is earlier.

b. **Inpatient Mental Health and Substance Abuse Services. All** hospitalizations for Mental Health and Substance Abuse services require precertification. A Member must contact CareFirst or its designee (or have his or her physician or the hospital contact CareFirst or its designee) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five business days due to medical condition, CareFirst must receive notification of the admission as soon as possible but in any event within 48 hours following the beginning of the admission or the end of the first business day following the beginning of the admission, whichever is earlier.

2.6 Concurrent Review and Discharge Planning. Following timely notification as described above in Section 2.5, CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of approved treatment.

2.7 Case Management. Case Management is used to coordinate, monitor and manage highly complex, long-term and costly cases. A Member's case manager can help the Member and such Member's provider arrange and coordinate home care services and other needed services. In performing case management, CareFirst reviews the Member's health care situation to determine how health needs can best be met within existing health care benefits. If special benefits are required, CareFirst may recommend alternative levels of care such as skilled nursing facilities, home health care or hospices. Following timely notification as described above in Sections 2.3 and 2.4 CareFirst will instruct the Member regarding the procedure for Case Management Review.

2.8 Appealing a Utilization Management Decision. If a Member or Member's provider disagrees with a utilization management decision, the decision will be reviewed upon request. If necessary, the Medical Director or Associate Medical Director will discuss the Member's case with the Member's physician. Any non-certification or penalty may be appealed. Please refer to the Customer Satisfaction in Section 6 of the Program Description.

SECTION 3
PHYSICIAN AND PROVIDER SERVICES

3.1 Preventive Services. Coverage will be provided for the following preventive services:

a. Well child visits through the age set out in the Benefits Schedule, Section 12, including examination, laboratory tests, and vaccinations, provided these services are **not** required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

b. Adult preventive physical examinations including examination, laboratory tests, and vaccinations, subject to the benefit limits described in Section 12. These services are **not** covered if required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

c. Pap smears, at intervals appropriate to the Member's age and health status.

d. Mammography services, at intervals described in the Benefits Schedule, Section 12.

e. Other preventive services, if any, as set forth in the Benefits Schedule, Section 12.

3.2 Diagnostic and Treatment Services. Coverage will be provided for diagnostic and treatment services by a physician or other Health Care Practitioner. Coverage includes the following services in a medical office or as a hospital outpatient:

a. Office visits, including care and consultation by physicians and specialists. Coverage does not include charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;

b. Diagnostic procedures, laboratory tests and x-ray services, including:

- electrocardiogram, electroencephalogram; tonography;
- laboratory services;
- diagnostic x-ray services, diagnostic ultrasound services;

c. Treatment and therapeutic services in connection with a covered procedure, including:

- chemotherapy (benefits for high dose chemotherapy are limited to covered procedures set forth in section 3.12);
- electroshock therapy;
- radiation therapy;
- radioisotope services;

d. Allergy tests, injections, and sera;

e. Speech therapy, occupational therapy or physical therapy for conditions that CareFirst determines are subject to improvement. Coverage does not include maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;

f. Services in connection with covered Hospital Emergency Room Services (see section 4.4)

3.3 Maternity and Related Services. The following services are covered for all Members, subject to the limitations set forth in the Benefits Schedule:

a. Obstetrical care for an ectopic pregnancy, miscarriage or complications of pregnancy. Obstetrical care for a normal pregnancy, including cesarean section if medically indicated, abortion, or delivery, including prenatal care and postnatal care. Coverage includes cesarean section if medically indicated, abortion, or delivery, including prenatal care and postnatal care. Under federal law, the mother has the option to remain in the hospital up to 48 hours for a vaginal delivery or up to 96 hours for a cesarean delivery.

b. Routine newborn care while the mother is hospitalized for covered maternity care, provided the mother is a Member and eligible for extended maternity benefits. Under federal law, the mother may request that the newborn also remain in the hospital for up to 4 days. Coverage is limited to routine newborn visits (not to exceed two visits) and male circumcision. To qualify for coverage of other services, the newborn must be a Member in his or her own right.

c. Voluntary sterilization of adult Members.

d. Diagnosis and treatment of infertility, excluding assisted reproductive procedures such as artificial insemination, in vitro fertilization, embryo or ovum and gamete or zygote intra-fallopian transfers.

NOTE: All coverage will be in accordance with published recommendation of American College of Obstetricians and Gynecologists (ACOG.)

3.4 Surgical Care (Inpatient and Outpatient). Coverage will be available for surgical procedures performed by Health Care Practitioners on an outpatient basis, or a covered inpatient hospital admission for which benefits are being provided under Section 4, subject to the applicable Utilization Management Requirements set out in Section 2.

If two or more surgical procedures are performed during the same operative episode, CareFirst will review the procedures to determine whether the individual procedures constitute separate and distinct procedures or incidental components of a more comprehensive procedure. If CareFirst determines that the procedures are in fact merely components of a more comprehensive procedure, coverage will be based on the Program Allowance for a single procedure, only. If it determines that multiple, distinctly identifiable surgical procedures were performed, the primary procedure will be covered at the full Program Allowance; the Program Allowances for other procedures performed during the same operative episode will be reduced in accordance with established Program guidelines. The Program Allowance guidelines may be obtained from the Customer Service Representative.

3.5 Inpatient Medical Care. The following Inpatient Medical Care services are covered under the Program, but only if a Member is an inpatient in a Hospital and is otherwise covered under Section 4 for the very day on which the services are rendered to the Member.

a. Health Care Practitioner visits during the Hospital stay. Coverage is not available for inpatient visits on any day on which benefits for hospitalization have been denied.

b. Intensive care which requires a Health Care Practitioner's attendance;

c. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

d. Inpatient diagnostic and treatment services provided and billed by a physician or other Health Care Practitioner, including:

- Diagnostic procedures, laboratory tests and x-ray services, including:
  - electrocardiogram, electroencephalogram; tonography;
  - laboratory services;
  - diagnostic x-ray services, diagnostic ultrasound services;
- Treatment and therapeutic services in connection with a covered procedure, including:
  - chemotherapy (benefits for high dose chemotherapy are limited to covered procedures set forth in section 3.12);
  - electroshock therapy;
  - radiation therapy;
  - radioisotope services;
  - physical therapy and inhalation therapy.

The Health Care Practitioner services identified in this section, including physician visits, charges for intensive care or consultative services, will be covered only if CareFirst determines that the Health Care Practitioner rendered the services to the Member and that such services were medically required to diagnose or treat the Member's condition.

3.6 **Anesthesia Service**. Coverage is available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, the anesthesia must be administered by a Health Care Practitioner other than the operating surgeon or assistant at surgery. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

3.7 **Blood and Blood Products**. Benefits for blood and blood products (including derivatives and components) which are not replaced by or on behalf of the Member.

3.8 **Ambulance Services**.

a. **To or From Hospital.** Except as provided in paragraph b, below, coverage of ambulance services is limited to medically necessary ambulance services to or from the nearest appropriate Hospital (as defined in section 4.1).

b. **Foreign Transportation.** If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available. Coverage includes air or ground ambulance services as Medically Necessary as defined in section 11.1.

3.9 **Reconstructive Breast Surgery.** Coverage will be provided for Reconstructive Breast Surgery resulting from Mastectomy, as these terms are defined below.

a. **Mastectomy** means the surgical removal of all or a part of a breast as a result of breast cancer.

b. **Reconstructive Breast Surgery** means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts. Reconstructive Breast surgery includes the augmentation mammoplasty, reduction mammoplasty and mastopexy. Covered Reconstructive Breast Surgery includes all stages of Reconstructive Breast Surgery performed on a nondiseased breast to establish symmetry with the diseased breast when Reconstructive Breast Surgery on the diseased breast is performed.

3.10 **Dental Services**.

a. Coverage will be provided to repair or replace sound natural teeth that have been damaged or lost due to injury if:

- The Member suffered bodily injury in addition to the dental injury;
- The injury did not arise while or as a result of biting or chewing;
- Treatment is commenced within six (6) months of the injury or, if due to the nature of the injury treatment could not begin within 6 months of the injury, treatment began within 6 months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

b. Dental benefits, including orthodontic treatment, will be provided for treatment of cleft lip or cleft palate.

c. **Except as listed above, coverage of dental care is limited to the benefits described in Attachment D.** Benefits for oral surgery are described in section 11.6.

3.11 **Organ/Tissue Transplants**. Coverage for organ and tissue transplants is limited to the following procedures:

a. Kidney; cornea; bone; skin (for grafting or for any other medically necessary purposes);

b. Heart; combined heart and lung; single lung; double lung; pancreas, when performed simultaneously with a kidney transplant; liver. Prior to commencing a course of treatment for these procedures, a Member must obtain CareFirst's written approval for both the procedure and the facility where the transplant will be done. No benefits will be provided for the facility, the procedure, or any resulting complication if the Member did not receive advance written approval.

c. Autologous bone marrow for:

- Non-Hodgkin's lymphoma, Stage III A or B, or State IV A or B;
- Hodgkin's lymphoma Stage III A or B, or Stage IV A or B;
- Neuroblastoma, Stage III or Stage IV;
- Acute lymphocytic leukemia following first or second relapse;
- Acute non-lymphocytic leukemia following first or second relapse;
- Germ cell tumors

NOTE: Autologous bone marrow transplant or stem cell transplant in connection with covered high dose chemotherapy treatment are covered only as described in section 3.12, below.

d. Allogeneic bone marrow for:

- Aplastic anemia;
- Acute leukemia;
- Severe combined immunodeficiency;
- Wiskott-Aldrich syndrome;
- Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
- Chronic myelogenous leukemia (CML);
- Neuroblastoma Stage III or IV in children over one year of age;
- Homozygous beta thalassemia (thalassemia major);
- Hodgkin's lymphoma, Stage III A or B, or Stage IV A or B;
- Non-Hodgkin's lymphoma, Stage III A or B, or Stage IV A or B;
- Myelodysplastic syndromes
- Mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy)
- Mucopolysaccharidosis (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants)

NOTE: Allogeneic bone marrow transplant or stem cell transplant in connection with covered high dose chemotherapy treatment are covered only as described in section 3.12, below.

If the Member is the recipient of a covered organ/tissue transplant, the Program will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract. If the donor is a Member but the recipient is not a Member, no benefits are available for either the Member or the recipient. Donor Services consist of services covered under the Program that are related to the surgery, including evaluating and preparing the actual donor and recovery services after the operation that are directly related to donating the organ or tissue. Donor Services include care and treatment of complications that are a direct and proximate result of the surgery and procedures involved in donating the organ but does not include long-term or secondary effects of having donated the organ.

All charges directly or indirectly relating to the transplantation of non-human organs are excluded.

3.12 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant. Coverage for High Dose Chemotherapy/ Bone Marrow or Stem Cell Transplant (HDC/BMTSCT) treatment will be provided as follows:

a. Coverage will be provided for HDC which is applied in connection with bone marrow or stem cell transplant for applicable conditions listed in section 3.11.c and 3.11.d, above;

b. If HDC is applied in connection with a covered condition that is **not** listed in section 3.11.c or 3.11.d, above, including, but not limited to, breast cancer, multiple myeloma and epithelial ovarian cancer, the HDC/BMTSCT will be covered only if the following requirements are satisfied:

- Coverage will be provided only if the Member/patient is properly and lawfully registered in a CareFirst -Certified Controlled Clinical Trial, as defined below. The patient must meet and continue to meet all eligibility requirements for participation in the trial as established by the CareFirst -Certified Controlled Clinical Trial;

  A **CareFirst -Certified Controlled Clinical Trial** means HDC/BMTSCT treatment that CareFirst has reviewed and determined, in advance of the Member's treatment, is:

  - Approved as a controlled clinical trial by the institutional review board of the institution providing treatment;
  - Conducted for the primary purpose of determining whether or not a particular HDC/BMTSCT treatment is safe and-efficacious; and
  - Approved by:

    An institute or center of the National Institutes of Health;

    U.S. Food and Drug Administration;

    U.S. Department of Veterans' Affairs; or

    U.S. Department of Defense.

- Coverage requires prior approval by CareFirst. The Member or his or her provider must notify CareFirst when first evaluated as a possible recipient of HDC/BMTSCT in a clinical trial that meets the conditions subject to this paragraph, but in any event prior to the Member's registration in the trial. Based on the information provided and that CareFirst obtains from the facility or provider, CareFirst will determine the Member's eligibility for coverage, including whether the facility and trial meet the requirements of a CareFirst-Certified Controlled Clinical Trial.

- Coverage will be provided subject to all limitations and conditions of the Program, including utilization management requirements, except as specifically modified by the terms of this Section. Coverage will not be provided for non-covered expenses, including transportation, lodging or meals or for services or supplies to the extent that they are provided without charge or at a reduced charge to other participants in the CareFirst-Certified Controlled Clinical Trial who do not have insurance coverage for those expenses.

NOTE

Participation in a controlled clinical trial, including a CareFirst-Certified Controlled Clinical Trial, does not guarantee that the patient will receive the treatment being evaluated by the trial. In a randomized clinical trial, some patients may be treated under one or more alternative protocols as a control to assess the safety and effectiveness of the treatment that is being evaluated under the study. The Program does not guarantee that a Member will be accepted for participation in a CareFirst-Certified Controlled Clinical Trial or that a Member will receive HDC/BMTSCT in a CareFirst-Certified Clinical Trial to which he or she has been accepted.

Coverage of HDC/BMTSCT for conditions listed in sections 3.11.c and 3.11.d does not require participation in a controlled clinical trial. For covered conditions that are **not** listed in sections 3.11.c or 3.11.d, coverage of HDC/BMTSCT requires the patient's participation in a CareFirst-Certified Controlled Clinical Trial. Coverage will not be provided if the patient is not participating in a CareFirst-Certified Controlled Clinical Trial for any reason, including the unavailability of a CareFirst-Certified Controlled Clinical Trial, the patient's ineligibility for participation in a CareFirst-Certified Controlled Clinical Trial or the patient's unwillingness to participate in a CareFirst-Certified Controlled Clinical Trial or to accept the conditions and requirements for participation in a CareFirst-Certified Controlled Clinical Trial.

SECTION 4
HOSPITAL SERVICES

The Program will cover services at a Hospital (defined below) either as an inpatient or as an outpatient. Generally, when a Member receives care at a Hospital, the services include both a professional component and an institutional component. For example, if the Member has surgery, the Hospital may charge the Member for the operating room and equipment while the surgeon, anesthesiologist and radiologist may charge separately for their services. Coverage for professional services of Health Care Practitioners are described in Section 3; the coverage described in this Section applies to the institutional services that are provided and billed by the Hospital.

4.1 Hospital Defined. The benefits of this Section apply only to institutions that are operated in accordance with the laws regulating hospitals within the jurisdiction in which they are located and are primarily engaged in providing, for compensation on an inpatient basis, diagnostic and therapeutic facilities for surgical and/or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed doctors of medicine, and which continuously provides twenty-four (24) hour a day nursing service by registered graduate nurses, and which is not, other than incidentally, a place for the aged, or a nursing or convalescent home or institution.

4.2 Inpatient Hospital Services. The following inpatient hospital services are covered:

a. Semiprivate room (2 or more patients);

b. Private room and board accommodations but only if:

- no semiprivate rooms are available at the time of admission (until one becomes available) or
- the Member must be isolated to prevent contagion; or
- the law requires isolation due to a communicable disease or an infectious condition.

c. Operating, recovery, anesthesia, intensive care, coronary care and cystoscopic room;

d. If maternity benefits are covered under section 3.3, labor and delivery room costs will be covered. Routine nursery care is covered while the mother is hospitalized for covered maternity care, provided the mother is a Member who is eligible for maternity benefits. The mother may request that the newborn also remain in the hospital for up to 4 days. Coverage of Hospital Services is limited to routine nursery care. To qualify for coverage of other Hospital Services, the newborn must be a Member in his or her own right.

e. Anesthesia materials;

f. Meals, including special diets;

g. General nursing service (inpatient private duty nursing is excluded unless CareFirst determines that adequate nursing care for critically ill patients is not available);

h. Drugs and medicines provided by the Hospital while the Member is a patient in the Hospital, including intravenous solutions and injections, provided that such drugs and medications are listed in the latest edition of "The United States Pharmacopoeia Dispensing Information," "The American Hospital Formulary Service Drug Information" or "The American Medical Association Drug Evaluations" at the time they are administered to the Member;

i. Oxygen, including the use of equipment for its administration;

j. Blood handling; sera (including blood, blood plasma and blood expanders);

k. Inpatient diagnostic and treatment services provided and billed by the Hospital, including:

- Diagnostic procedures, laboratory tests and x-ray services, which in turn include:
  - electrocardiogram, electroencephalogram; tonography;
  - laboratory services;
  - diagnostic x-ray services, diagnostic ultrasound services;

- Treatment and therapeutic services in connection with a covered procedure, including:
  - chemotherapy (benefits for high dose chemotherapy are limited to covered procedures set forth in section 3.12);
  - electroshock therapy;
  - radiation therapy;
  - radioisotope services;
  - physical therapy and inhalation therapy.

l. All other care in the nature of usual hospital services that are medically necessary for the care and treatment of the patient, provided that those services cannot be rendered in an outpatient setting and are not otherwise specifically excluded under the Program.

4.3 Outpatient Hospital Care. The following outpatient services rendered in the outpatient department of a Hospital or in an ambulatory surgical facility, in connection with a covered medical or surgical procedure under Section 3 are covered:

a. Use of operating room and recovery room;

b. Use of special procedure rooms;

c. Hemodialysis;

d. Laboratory, x-ray and machine tests;

e. Chemotherapy and radiation therapy (benefits for high dose chemotherapy are limited to covered procedures set forth in section 3.13);

f. Cardiac rehabilitation if:

- The Member has been diagnosed as having angina pectoris or has been hospitalized for a diagnosed myocardial infarction or coronary surgery; and
- The program is approved in advance by CareFirst as meeting the following requirements:
  - The program must be provided or coordinated by a Hospital or other facility that CareFirst has previously approved to provide these services;
  - The program must provide continuous cardiac rehabilitative exercise, education and counseling; and
  - A list of approved cardiac rehabilitation providers is available upon request from the CareFirst Customer Service Representative.

4.4 Emergency Room Services. Services received in or through a Hospital emergency room and which qualify as a "Medical Emergency" are covered, as defined below.

A **Medical Emergency** is the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected (by a prudent person who possesses an average knowledge of health and medicine) to result in: (i) serious jeopardy to the patient's health; or (ii) serious impairment of the patient's bodily functions; or (iii) serious dysfunction of any of the individual's bodily organs or parts; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Examples might include, but are not limited to, chest pain, uncontrollable bleeding, extreme difficulty breathing, loss of consciousness, severe pain, poisonings, and other acute conditions.

SECTION 5
HOME HEALTH CARE SERVICES

5.1 Qualified Home Health Agency. The services described in section 5.2 are covered only when the patient is under the care of a Qualified Home Health Agency, as defined below.

> A **Qualified Home Health Agency** is a licensed program which is a Participating Provider or which is approved for participation as a home health agency under Medicare or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations or any successor.

5.2 Covered Home Health Care. The home health services listed below are covered when care is received from a Qualified Home Health Agency.

a. Part-time or intermittent home nursing care by a licensed professional (LPN or RN) nurse.

b. Respiratory, speech, audiology, physical and occupational therapy that CareFirst determines will result in improvement of a Member's condition and achieve demonstrable treatment objectives, as identified in the Qualified Home Health Agency's treatment plan.

c. Part-time or intermittent home health aide services (the Member must require and continue to require skilled nursing care or rehabilitation services in order to qualify for home health aide services).

d. Drugs and medications directly administered to the patient during a covered home health visit, including home intravenous infusion therapy and incidental medical supplies directly expended in the course of a covered home health visit. Drugs and medications that may be self-administered and are not taken under the direction of a physician (other than as described above) are not covered, except as provided in Attachment C. Medical supplies and purchase or rental of durable medical equipment are covered under Section 9.

e. Diagnostic tests and laboratory services.

f. Services of a medical social worker.

g. Nutrition guidance under the direction of a registered dietitian.

h. Ambulance services to or from a Hospital when a Member's condition is such that other methods of transportation would be hazardous to his or her health.

5.3 Conditions for Coverage. Home Health Services must be authorized or approved by CareFirst under utilization management requirements as meeting the following conditions for coverage:

a. The Member must be confined to "home" due to a medical condition. "Home" cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled or injured persons.

b. The home health visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if home health visits were not provided, the Member would have to be admitted to a Hospital or Skilled Nursing Facility).

c. The Member must require and continue to require skilled nursing care or rehabilitation services. "Skilled nursing care" means non-custodial care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

d. The home health services must not constitute custodial care (see section 5.4, below).

e. The plan of treatment covering the Home Health Care service is established and approved in writing by the attending physician.

f. Services of a home health aide, medical social worker or registered dietitian must be performed under the supervision of a licensed professional (L.P.N. or R.N.) nurse.

g. All services must be arranged and billed by the Qualified Home Health Agency. Home health care providers may **not** be retained directly by the Member.

5.4 Custodial Care Is Not Covered. Benefits (for home health services or any other services) will not be covered if CareFirst determines that such visits or services were provided primarily for custodial care. Custodial care is care that does **not** require the continuing attention of trained, professional medical personnel. Custodial Care is care that is primarily for the purpose of meeting personal, daily living needs and that can be learned and provided by an average individual who does not have professional medical skills and training. Examples of custodial care include:

a. Assistance in performing the activities of daily living, such as feeding, dressing, and personal hygiene;

b. Administration of oral medications, routine changing of dressing, or preparation of special diets; or

c. Assistance in walking or getting in or out of bed.

These services are custodial even if the Member cannot provide this care for himself or herself because of age or illness and even if there is no one in the Member's household who can perform these services for the Member.

SECTION 6
SKILLED NURSING FACILITY SERVICES

6.1 Covered Skilled Nursing Facility Services. The services listed below are covered only if they are provided in a "Qualified Skilled Nursing Facility," as defined below and are provided during a confinement approved by CareFirst.

a. Room and board in a semiprivate room.

b. The following inpatient physician and medical services, if CareFirst determines that the Health Care Practitioner rendered the services and that such services were medically required to diagnose or treat the Member's condition. In addition, these services must be rendered during a confinement approved by CareFirst:

- Health Care Practitioner visits during Skilled Nursing Facility stay. Coverage is not available for inpatient visits on any day on which benefits for Skilled Nursing Facility services have been denied.
- Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

c. Services and supplies ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

- Use of special equipment in the facility.
- Drugs, medications, solutions, biological preparations, and medical supplies used while the Member is an inpatient in the facility.

6.2 Qualified Skilled Nursing Facility. A "Qualified Skilled Nursing Facility" is a licensed facility which is approved for participation as a Skilled Nursing Facility under Medicare or certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or any successor. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

6.3 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by CareFirst and must meet the following conditions before services provided in such facility will be covered:

a. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

b. The Member must require skilled nursing care or skilled rehabilitation services which:

- Are required on a daily basis;
- Are not custodial (see Section 5.4, above); and
- Can only be provided on an inpatient basis.

c. The admission and continued confinement must be certified by CareFirst as meeting the criteria for coverage.

SECTION 7
HOSPICE CARE SERVICES

7.1 Covered Hospice Care Services. Coverage will be provided for the services listed below when provided by a Qualified Hospice Care Program, as defined below.

a. Intermittent nursing care by or under the direction of a registered nurse

b. Medical social services for the terminally ill patient and his or her "Immediate Family." Immediate Family means the patient's spouse and children or, if the terminally ill patient is a child, the parents, brothers and sisters of the child.

c. Nutritional guidance.

d. Non-custodial home health visits as described in Section 5.

e. Medical/surgical supplies.

f. Laboratory tests and x-ray services.

g. Ambulance services, when medically required.

h. Family counseling and bereavement services will be provided to the Immediate Family when authorized or approved by us and subject to the benefit limits set forth in the Schedule of Benefits.

7.2 Conditions for Coverage. To be covered, the Hospice Care Services must be provided by a Qualified Hospice Care Program (as defined below) and meet the following conditions:

a. The Member must have a life expectancy of six months or less.

b. The Member's attending physician must submit a written plan of treatment to CareFirst.

c. The Member must meet the criteria of the Qualified Hospice Care Program.

d. The need and continued appropriateness of Hospice Care Services must be certified by CareFirst as meeting the criteria for coverage in accordance with CareFirst's utilization management requirements.

7.3 Qualified Hospice Care Program. A "Qualified Hospice Care Program" is a coordinated, interdisciplinary program provided by a Hospital, Qualified Home Health Agency or other Health Care Facility for meeting the special physical, psychological, and social needs of dying individuals and their families, and which is licensed or certified by the state in which it operates as a hospice program.

7.4 Hospice Stay Period. A Hospice Stay Period begins on the first date hospice services are rendered and terminates 180 days later or on the death of the terminally ill Member, if sooner. In individual cases, a Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the eligibility period on an individual case basis, if it determines that the patient's prognosis and continued need for services are consistent with a program of Hospice Care.

7.5 Hospice Benefits Not Provided. The following services are not covered by the Hospice Care Program:

a. Services, visits, medical equipment or supplies that are not included in 's approved plan of treatment.

b. Financial and legal counseling.

c. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

d. Reimbursement for volunteer services.

e. Chemotherapy or radiation therapy, unless used for symptom control.

SECTION 8
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

8.1 Definitions. The following terms have the meanings described below:

a. **Alcohol Abuse** means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

b. **Clinically Significant** means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

c. **Drug Abuse** means any pattern of pathological use of drugs that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

d. **Inpatient Services** mean therapeutic services and supplies that are Medically or Psychologically Necessary and that are provided in a Hospital or Non-Hospital Residential Facility to a patient according to an individualized treatment plan that requires the patient to be admitted.

e. **Medically or Psychologically Necessary** means essential for the treatment of Substance Abuse, or Mental Health as determined by a physician, psychologist or social worker; or as determined by the Plan.

f. **Mental Health** means any mental disorder, mental illness, psychiatric illness, mental condition or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC)

g. **Non-Hospital Residential Facility** means a facility certified by the District of Columbia or by any jurisdiction in which it is located as a qualified non-hospital provider of treatment for Substance Abuse, Mental Health, or any combination of these, in a residential setting. The term Non-Hospital Residential Facility includes any facility operated by the District, any state or territory, or the United States to provide these services in a residential setting. A Non-Hospital Residential Facility also must meet or exceed guidelines established for such a facility by us and as amended from time to time. It is not a facility licensed as a general or special hospital.

h. **Outpatient Services** mean therapeutic services and supplies that are Medically or Psychologically Necessary, and which are provided to a patient according to an individualized treatment plan that does not require the patient to be admitted to a Hospital or Non-Hospital Residential Facility. The term Outpatient Services refers to services and supplies that may be provided in a Hospital, a Non-Hospital Residential Facility, an Outpatient Treatment Facility or a Health Care Practitioner's office.

i. **Outpatient Treatment Facility** means a clinic, counseling center, or other similar location that is certified by the District of Columbia, or by any jurisdiction in which it is located as a qualified provider of outpatient services for the treatment of Substance Abuse, or Mental Health. The term Outpatient Treatment Facility includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

j. **Quarterway House** means a residential facility for people who show the effects of Substance Abuse in which further use of alcohol or drugs is prevented and the pain caused by withdrawal is relieved.

k. **Rehabilitation Home** means a residential facility for people who show the effects of Substance Abuse and would be helped by a residential rehabilitation program.

l. **Therapy Service** means services rendered by an Eligible Provider to rehabilitate a Member who shows the effects of Substance Abuse including: psychotherapy; counseling; family therapy; drug therapy; behavior therapy; occupational therapy; and recreational therapy.

m. **Treatment Facility** means an Outpatient Treatment Facility, Quarterway House, Non-Hospital Residential Facility, Rehabilitation Home or Hospital which operates a rehabilitation program for people who show the effects of Substance Abuse. For the purposes of the diagnosis, care and treatment of Mental Health the term Treatment Facility means a Hospital, Non-Hospital Residential Facility or Outpatient Treatment Facility only. It must be licensed or certified by the proper authority in the area where the facility is located.

8.2 **Covered Services.** To be eligible for benefits, a Health Care Practitioner must certify that the Member is suffering from Clinically Significant Mental Health, Substance Abuse and prescribe Medically or Psychologically Necessary treatment (which may include referral to another Eligible Provider) which must be pre-authorized in accordance with CareFirst's Utilization Management Requirements. These benefits are subject to all terms of the Contract.

a. **Outpatient Services.** Benefits are available for Outpatient Services (as described above) rendered by an Eligible Provider for the Medically or Psychologically Necessary treatment of Clinically Significant Mental Health, Substance Abuse.

b. **Inpatient Services.** Benefits are available for Inpatient Services (including Therapy Services as described above) rendered by a Treatment Facility for the Medically or Psychologically Necessary treatment of Clinically Significant Mental Health, Substance Abuse.

The following Inpatient Health Care Practitioner benefits apply only if the Member is eligible for Hospital Benefits under Section 8.2 b. above **for the day on which these services are rendered to the Member**:

- Health Care Practitioner visits during a covered Inpatient Treatment Facility stay. Also, benefits are not available for inpatient visits or consultations on any day on which Treatment Facility benefits have been denied.
- Intensive care which requires a Health Care Practitioner's attendance;
- Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

Health Care Practitioner services provided to a hospitalized Member, including physician visits, charges for intensive care or consultative services will be covered only if CareFirst determines that the Health Care Practitioner rendered services to the Member and that such services were Medically or Psychologically Necessary or required to diagnosis or treat the Member's condition.

Coverage for inpatient Mental Health and Substance Abuse Services is subject to CareFirst's certification of the need and continued appropriateness of such services in accordance with Utilization Management Requirements of the Program.

8.3 **Covered Mental Health Services.** Benefits will be provided for the services listed above for Medically or Psychologically Necessary diagnosis, care and treatment of Clinically Significant Mental Health as defined in Section 8.1. Coverage of Mental Health Services is subject to the limits described in the Benefit Schedule, including limits on numbers of visits and days covered and, if applicable, limitations on the total benefits available for these services, and the Exclusions as described in Section 11 hereof. In addition, coverage for Mental Health Services is subject to CareFirst's certification of the need and continued appropriateness of such services in accordance with CareFirst's Utilization Management Requirements.

8.4 **Covered Substance Abuse Services.** Benefits will be provided for the services listed above for Medically or Psychologically Necessary diagnosis, care, and treatment of Clinically Significant Substance Abuse, as defined in Section 8.1, including detoxification. Coverage of Substance Abuse Services is subject to all terms and conditions of this Program, including the limits described in the Schedule of Benefits and the exclusions described in Section 11 hereof. In addition, coverage for Substance Abuse Services is subject to CareFirst's certification of the need and continued appropriateness of such services in accordance with the utilization management requirements of the Program.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

9.1 Benefits Provided. Coverage will be provided for certain types of Medical Devices and Medical Supplies (as defined below). To qualify for benefits, the Member must be enrolled in the Program at the time that the supply, equipment, prosthetic or appliance is prescribed and received. The Medical Devices and Medical Supplies must be ordered by a provider. When Durable Medical Equipment is rented, the Member must continue to be eligible to receive benefits for the duration of time for which the equipment is authorized.

9.2 Definitions

a. **Covered Medical Device.** Covered Medical Device means Covered Durable Medical Equipment, Covered Prosthetic Devices and Covered Corrective Appliances

- **Covered Durable Medical Equipment** means equipment furnished by a supplier, Qualified Home Health Agency or Hospice Care Program which is primarily and customarily used to serve a medical purpose; can withstand repeated use; generally is not useful to a person in the absence of illness or injury; is appropriate for use in the home; and is necessary and reasonable for the care or treatment of the Member's illness or injury. All requirements of this definition must be met before an item can be considered Covered Durable Medical Equipment. Items such as hospital beds, wheelchairs, home dialysis equipment, apnea monitors, oxygen equipment, crutches, respirators, commodes and suction machines are examples of Covered Durable Medical Equipment.
- **Covered Prosthetic Device** means an externally worn device which replaces a body part or performs or assists the patient in performing a bodily function. Covered Prosthetic Devices do not include eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients, as described below), or dental prosthetics. Artificial limbs, breast prosthesis, and implanted prosthetic devices, such as pacemakers and hip or knee joints, are examples of Covered Prosthetic Devices. If a Member is aphakic due to intraocular surgery or an accidental injury, the Program will cover one pair of eyeglasses or contact lenses used to replace the natural lens and subsequent changes required due to a change in prescription.
- **Covered Corrective Appliance** means an externally worn brace which supports, aligns or corrects deformities to or improves the function of a limb or other moving body part, including soft or rigid gas permeable contact lenses or sclera shells for use in the treatment of a condition other than correction of vision. Corrective braces, casts, and slings are examples of Covered Corrective Appliances.

b. **Covered Medical Supply.** Benefits for Covered Medical Supplies are limited to the items listed below. To qualify for coverage, Medical Supplies must be prescribed or ordered by a Health Care Practitioner for the Member's own use and must be determined by us to be medically necessary and compatible with the diagnosis:

- Diabetic diagnostic supplies used to test blood and urine for glucose and used by a patient at home, including testing supplies for special diabetic equipment;
- Disposable syringes necessary to self-administer insulin or other covered injectables;
- Ostomy and catheter supplies;
- Dialysis supplies;
- Oxygen;
- Medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism;
- Dressings required in connection with a covered injury, surgical procedure or condition.

9.3 Exclusions and Limitations.

a. Coverage will **not** be provided for purchase, rental or repair of:

- Medical equipment/supplies of an expendable nature, except as specifically listed as a covered medical supply in Section 9.2.b., above. Non-covered supplies include incontinence pads or ace bandages.
- Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench.
- Eyeglasses or contact lenses (except as stated above) hearing aids or dental prostheses or appliances.
- Corrective shoes (unless required to be attached to a leg brace), shoe lifts or special shoe accessories.

b. Coverage will be limited to the lower of the cost to purchase or rent, taking into account the length of time the Member is required or is reasonably expected to require the equipment, the durability of the equipment, etc.

c. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device or equipment not determined by us to be medically necessary, the Program will pay an amount which does not exceed CareFirst's payment for the basic device (minus the Member copayment) and the Member will be fully responsible for paying the remaining balance.

d. Coverage for the repair, maintenance or replacement of Covered Durable Medical Equipment will be limited as follows:

- Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
- Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to continue to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic, orthotic or equipment.
- Replacement coverage is limited to once every two years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are NOT covered.

9.4 Responsibility of CareFirst. The Program will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of prosthetic or orthotic devices, corrective appliances or durable medical equipment, whether or not covered under this Agreement.

SECTION 10
VISION CARE SERVICES

10.1 Benefits for Covered Vision Services. Benefits will be provided for the following Covered Vision Services when rendered by a Vision Services Provider:

Covered Vision Services	Special Limitations	Program Covers
Eye Examination Limited to examination to determine visual defects and ocular refractive deformities and deficiencies of the human eye, including refraction and prescription. A medical doctor or optometrist may perform such an examination.	Limited to 1 examination (eye examination or comprehensive eye examination) every other calendar year	100% of reasonable charges, up to $100
Comprehensive Eye Examination In addition to the services included in an Eye Examination, as described above, a Comprehensive Eye Examination is designed to detect those diseases and abnormalities of the body which can be determined through examination of the eye. Only a medical doctor may perform such an examination		100% of reasonable charges, up to a maximum Program payment of $100

Covered Vision Services	Special Limitations	Program Covers
Frames, lenses and contacts	Limited to: • one pair of lenses and a set of frames OR • one pair of contact lenses one every other calendar year	80% of reasonable charges, up to the following maximum payments by the Program Single vision lens $ 130 per pair Bifocal lens $ 200 per pair Trifocal lens $ 250 per pair Frames $ 160 per set Contact lenses • Hard $ 175 per pair • Soft $ 300 per pair • Extended wear (disposable) $300 every other calendar year

10.2 Payments Under the Program. Payments for "Covered Vision Services" rendered by a "Participating Vision Services Provider" (as these terms are defined below) will be made directly to the provider or the provider's representative. If Covered Vision Services are received from any other Vision Services Provider, payment will be made to either the Enrollee or the Vision Services Provider. Payment will, in either case, be full and complete satisfaction of benefit and payment obligations under this Program.

a. **Covered Vision Services** means those eye care services and supplies for which benefits are provided under this Program.

b. **Vision Services Provider** means an optometrist, optician or ophthalmologist, licensed as such by the duly constituted authority in the area in which Covered Vision Services are rendered and when acting within the scope of such license.

c. **Participating Vision Services Provider** means a Vision Services Provider who, at the time of rendering Covered Vision Services to the Enrollee, has an agreement with CareFirst, or its designee, for the rendering of such services.

10.3 Exclusions

a. Services rendered prior to the effective date of the Enrollee's coverage under the Vision Program;

b. Services rendered subsequent to the effective date of the Enrollee's coverage under the Vision Program if such services were commenced prior to the effective date;

c. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof; and

d. Services or supplies in connection with special procedures, such as orthoptics and special training;

e. Eye exercises, including remedial reading exercises;

f. Duplicate or spare eyeglasses, or any lenses or frames for duplicate or spare eyeglasses or to replace eyeglasses that have been lost, stolen or broken;

g. Lenses that do not require and prescription or frames for such lenses;

h. Safety glasses or safety goggles;

i. Aniseikonoc lenses;

j. Subnormal visual aids;

k. Medical or surgical treatment of the eye; visual field examinations;

l. Drugs or any other type of medication, except as used in connection with a covered eye examination or visual analysis and included in the charge for the examination or analysis.

SECTION 11
EXCLUSIONS

11.1 Medical Necessity and Appropriateness. Coverage will not be provided for services, tests, procedures or supplies that CareFirst determines are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. **Although a service or supply is otherwise listed as covered, coverage will be provided only if it is medically necessary and appropriate in the Member's particular case.** A service, supply or procedure is Medically Necessary and appropriate only if, in CareFirst's judgment it is:

a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;

b. Consistent with the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;

c. The most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis;

d. Not primarily for the convenience of the Member, his or her family, or provider; and

e. Not a part of or associated with the scholastic educational or vocational training of the Member.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. CareFirst may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations a Member receives are Medically Necessary.

11.2 Accepted Medical Practice. Coverage will not be provided for any treatment, procedure, facility, equipment, drug, device or supply which, in CareFirst's judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service, device or supply is deemed to be experimental or investigational or not in accordance with accepted medical or psychiatric practice if:

a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature, has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;

b. It is not in accordance with standards of good and generally accepted medical practice within the organized medical communities of Maryland, Northern Virginia and the District of Columbia; or

c. It does not have federal or other required governmental agency approval at the time it is received.

The rules that CareFirst applies to determine Accepted Medical Practice may be different for National Accounts, or service obtained under the BlueCard Program.

11.3 Free Care. Coverage will not be provided for the cost of services that:

a. are furnished without charge;

b. would normally be furnished to the Member without charge; or

c. would have been furnished to the Member without charge if the Member were not covered either under the Program or under any other health benefits arrangement.

11.4 Routine Care of Feet. Coverage will not be provided for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet or partial removal of a nail without the removal of its matrix. However, coverage will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.

11.5 Dental Care. Except as provided in section 3.10, coverage will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia (including braces), false teeth or any other dental services or supplies, unless provided in a separate amendment to the Contract.

11.6 Oral Surgery. Coverage is limited to non-dental surgical procedures for congenital defects, such as hare lip or cleft palate and for medically necessary diagnostic and surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to procedures to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth; the reduction of, dislocation of, or excision of temporomandibular joints; procedures involving accessory sinuses, salivary glands or ducts; excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required; excision of exostosis of the jaw and hard palate when not related to the fitting of dentures; extraoral incision and drainage of abscesses with cellulitis. All other procedures involving the teeth or areas surrounding the teeth will not be covered, except for diagnostic and surgical treatment of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

11.7 Cosmetic Services. Coverage will not be provided for plastic surgery, cosmetic surgery or other procedures, services, equipment or supplies, primarily intended to correct, change or improve the Member's appearance. Except as provided in paragraph (b) below, such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of the patient's appearance may be psychologically or developmentally beneficial to the patient. The Program will, however, provide coverage for reconstructive surgery if, in CareFirst's judgment, such surgery is:

a. Medically necessary to correct conditions which have resulted in a functional physiological defect;

b. Required to correct a congenital anomaly (must be a physical defect that was apparent at birth) that has produced a major physical effect on the Member's condition and provided the surgery or procedure can be reasonably expected to correct the condition; or

c. Required to correct conditions which have resulted from accidental injury or non-cosmetic surgery if:

- The accident or surgery has produced a major physical effect on the Member's appearance; and
- In CareFirst 's judgment, the surgery can be reasonably expected to correct the condition.

11.8 Prescription Drugs. Coverage will not be provided for prescription drugs, except those administered to the Member in the course of covered outpatient or inpatient treatment. Except as provided in Attachment C, take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility.

11.9 Organ Transplants. Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in sections 3.11 and 3.12.

11.10 Neuromuscular Rehabilitation. Neuromuscular rehabilitation will be covered if limited to physical therapy services.

11.11 Other Exclusions. Coverage will not be provided for the following:

a. Services or supplies received before the effective date of the Member's coverage under this Agreement.

b. Treatment of sexual dysfunctions or inadequacies limited to surgical implants for impotence (medical therapy and psychiatric treatment are not covered).

c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

d. Weight reduction or obesity services or treatment.

e. Speech therapy, occupational therapy or physical therapy, unless CareFirst determines that the Member's condition is subject to improvement. Coverage does not include maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training, education, or therapy. Cardiac rehabilitation programs are covered as described in section 4.3.f.

g. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

h. Services to the extent they are covered by any governmental unit, except that services provided in Veteran's Administration or armed forces facilities, such as for non-service connected disabilities, for which the Member is liable will be covered. Services or supplies for injuries or diseases related to a enrolled Member's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

i. Services that are beyond the scope of the license of the provider performing the service.

j. Travel expenses, except for covered ambulance services, whether or not recommended by an Eligible Provider.

k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

m. Contraceptive devices, supplies or drugs.

n. Partial removal of a nail without the removal of the matrix.

o. Services solely on court order or as a condition of parole or probation unless approved by CareFirst.

p. Any illness or injury caused by war, declared or undeclared, including armed aggression.

q. Any service, supply or procedure that is not specifically listed in this Description as a covered benefit.

r. Biofeedback services

s. Premarital lab work required by law

t. Services to reverse voluntary, surgically induced infertility.

u. Insulin injections or insulin therapy, unless covered under the Prescription Drug part of the Program.

v. Mammoplasty, unless Medically Necessary to correct a physical functional impairment.

w. Sclerotherapy (injection of sclerosing solution) for treatment of varicose veins unless medically necessary.

x. Inpatient Private Duty Nursing.

y. RU-486.

SECTION 12
SCHEDULE OF BENEFITS

GENERAL PROGRAM BENEFIT FEATURES

DEDUCTIBLE
The Deductible applies to In-Network and Out-of-Network services, on a combined basis. Members can meet the Deductible through any combination of In-Network and/or Out-of-Network Deductible expenses. **The Benefit Chart, below indicates whether a covered service is subject to the Deductible.** The Individual Deductible is $ 125 per calendar year The Family Deductible is $ 325 per calendar year If the Employee/Member has Self-Only Coverage, he or she must meet the Individual Deductible Members covered under Family Coverage can satisfy their own Deductible by meeting the Individual Deductible. In addition, eligible expenses of three or more family members can be combined to satisfy the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members. An individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. The following amounts apply to the Deductible: • 100% of the Preferred Provider Allowance for covered In-Network services that are subject to the Deductible, as indicated in the Benefits chart below. • 100% of Program Allowance for covered Out-of-Network services that are subject to the Deductible, as indicated in the Benefits chart below. The following amounts may not be used to satisfy the Deductible: • Amounts incurred for failure to comply with the Utilization Management Program requirements • The portion of any provider charge for In-Network services that is in excess of the Preferred Provider Allowance • The portion of any provider charge for Out-of-Network services that is in excess of the Program Allowance
DEDUCTIBLE CARRYOVER PROVISION
If the deductible was not satisfied during the calendar year, any expenses applied to the deductible during the last three months of that calendar year can be counted toward the deductible for the following year.

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit applies to In-Network and Out-of-Network services, on a combined basis. Members can meet the Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network out-of-pocket expenses.

The Individual Out-of-Pocket Limit is $ 1,500 per calendar year

The Family Out-of-Pocket Limit is $ 3,000 per calendar year

If the Employee/Member has Self-Only Coverage, he or she must meet the Individual Out-of-Pocket Limit

Members covered under Family Coverage can satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, eligible expenses of three or more family members can be combined to satisfy the Family Out-of-Pocket Limit. An individual family member cannot contribute more than the Individual Out-of-Pocket Limit toward meeting the Family Out-of-Pocket Limit. This will satisfy the Out-of-Pocket Limit for all other covered family members.

When a Member has reached the Out-of-Pocket Limit, no further Coinsurance will be required in that calendar year for services subject to the Out-of-Pocket Limit.

These amounts apply to the Out-of-Pocket Limit:

- The Deductible
- Coinsurance for Covered In-Network and Out-of-Network Services,

The Benefit Chart, below indicates whether a covered service is subject to the Out-of-Pocket Limit.

The following amounts may not be used to meet the Out-of-Pocket Limit:

- Coinsurance for In-Network and Out-of-Network Services that are **not** subject to the Out-of-Pocket Limit, as designated in the Benefit Chart
- Coinsurance or Copayments, if any, for the following services:
  - Vision Care Services under Section 10;
  - Prescription Drug Benefits under Attachment C
  - Dental Care Services under Attachment D
- Amounts incurred for failure to comply with the Utilization Management Program requirements
- The portion of any provider charge for In-Network services that is in excess of the Preferred Provider Allowance
- The portion of any provider charge for Out-of-Network services that is in excess of the Program Allowance

LIFETIME MAXIMUMS
There is a General Lifetime Maximum which includes services for Mental Health and Substance Abuse (Mental Health/Substance Abuse) Services. **General Lifetime Maximum** The General Lifetime Maximum is $1,000,000 per Member Except as otherwise noted in the benefit chart below, the General Lifetime Maximum applies to 100% of the In-Network and Out-of-Network benefit payments made to or on behalf of the Member. **The Benefit Chart, below indicates whether a covered service is subject to the Out-of-Pocket Limit.** If the Member exceeds the General Lifetime Maximum, benefits for services that are subject to the General Lifetime Maximum will thereafter be limited to a General Restoration Allowance of $2,500 per calendar year. For the remainder of the calendar year in which the Member exceeds his or her Lifetime Maximum, the $2,500 Restoration Allowance will be reduced by the total amount of benefits received by the Member in that year before meeting the Lifetime Maximum. **Lifetime Maximum for Mental Health /Substance Abuse Services** The benefit chart, below, provides information concerning the specific Mental Health and Substance Abuse services that count toward the Lifetime Maximums. If the Member exceeds the Lifetime Maximum for Mental Health/Substance Abuse Services, benefits for services subject to the Mental Health/Substance Abuse Lifetime Maximum will thereafter be limited to a Restoration Allowance of $2,500 per calendar year. In addition, if the Member has also exceeded his or General Lifetime Maximum, benefits for Mental Health and Substance Abuse Services count toward the General Restoration Allowance as well as the Restoration Allowance for Mental Health/Substance Abuse Services. For the remainder of the calendar year in which the Member exceeds his or her Lifetime Maximum for Mental Health/Substance Abuse Services, the $2,500 Restoration Allowance will be reduced by the total amount of benefits for Mental Health and Substance Abuse Services received by the Member in that year before meeting the Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements will result in: Benefits for health care facility services associated with the care or treatment (except for inpatient maternity and related services) will be reduced by $250 per incident.

BENEFITS

PROGRAM ALLOWANCES

Preferred Providers. For services and supplies provided by Preferred Providers, the benefit payments are based on Preferred Provider Allowances.

Participating Providers. For services and supplies provided by Participating Providers, the Program Allowance is based on Participating Provider Allowances.

Non-Participating Providers. For services and supplies provided by Non-Participating Providers, the Program Allowance is based on the Participating Provider Allowances. Non-Participating Providers may bill Members for any balance above the Program Allowance.

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	SUBJECT TO OUT-OF-POCKET LIMIT?	SUBJECT TO LIFETIME MAXIMUM?	PROGRAM COVERS	
					IN-NETWORK	OUT-OF NETWORK
PHYSICIAN AND HEALTH CARE PRACTITIONER SERVICES						
NOTE: This section applies to the professional services of Physicians and other Health Care Practitioners. Except as noted below, benefits described apply on an inpatient or outpatient basis. However, if the Member receives Physician and Health Care Practitioner services while hospitalized or in a hospital outpatient department or outpatient facility, a separate hospital or facility charges may apply. Benefits for these separate charges may be different than the benefits paid for professional services. See Inpatient Hospital Services and Outpatient Hospital Services, below for additional benefits information.						
Preventive Services						
Child wellness	Up to age 18	NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Adult preventive physical examinations, (includes office visit, laboratory, related testing, routine pap smears and screening mammography)	Limited to one exam per calendar year Coverage subject to a combined (In-Network and Out-of-Network) benefit maximum as follows: Age 18 through 34 $350 per calendar year Age 35 through 49 $500 per calendar year Age 50 or above $750 per calendar year.	NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	SUBJECT TO OUT-OF-POCKET LIMIT?	SUBJECT TO LIFETIME MAXIMUM?	PROGRAM COVERS	
					IN-NETWORK	OUT-OF NETWORK
Diagnostic and Treatment Services						
Office visits Allergy tests, sera and injections Radiation therapy Chemotherapy		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Diagnostic lab, x-ray and machine tests		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Physical, speech, respiratory and occupational therapy		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Maternity and Related Services						
Delivery, including prenatal and postnatal care of mother		YES	YES	NO	90% of the Preferred Provider Allowance	90% of Program Allowance
In-Hospital newborn visits						
Up to 2 visits		NO	NO	NO	90% of the Preferred Provider Allowance	90% of Program Allowance
Additional visits		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Inpatient Physician and Health Care Practitioner services						
Visits by attending physician		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Consultations		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance

Service	Special Limitations	Subject to Deductible?	Subject to Out-of-Pocket Limit?	Subject to Lifetime Maximum?	Program Covers	
					In-Network	Out-of Network
Surgical Care						
	When performed in physician's office, limited to minor surgery, under $300	YES	YES	NO	90% of the Preferred Provider Allowance	90% of Program Allowance
Inpatient ancillary services, including radiology and pathology						
	Covered only if hospitalization qualifies for coverage	YES	YES	YES	90% of the Preferred Provider Allowance	90% of Program Allowance
Anesthesia Service						
	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure	NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Ambulance Service						
To or From Hospital		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Foreign Transportation	Applies only if Member is traveling outside the U.S.	YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	SUBJECT TO OUT-OF-POCKET LIMIT?	SUBJECT TO LIFETIME MAXIMUM?	PROGRAM COVERS	
					IN-NETWORK	OUT-OF NETWORK
HOSPITAL SERVICES						
Inpatient Hospital Services NOTE: Benefits for non-emergency inpatient hospital admissions are subject to a $250 deductible per person per calendar year. The inpatient hospital deductible applies on a combined basis to In-Network and/or Out-of-Network hospital admissions in each calendar year. Amounts incurred by Members for the inpatient hospital deductible do not count toward the Deductible or the Out-of-Pocket Limit as described under General Plan Features.						
Up to 180 days per confinement * A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days	Must be authorized in advance under utilization management program The Member's Preferred Provider will handle In-Network utilization management requirements on the Member's behalf	NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Additional days in excess of 180 days per confinement *		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
* The 180 day limit is reduced by Skilled Nursing Facility Services and inpatient Mental Health and Substance Abuse Services obtained by the Member during the same confinement, as defined above.						
Outpatient Hospital Services						
Outpatient Surgery		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Diagnostic lab, x-ray and machine tests Radiation therapy Chemotherapy (injection or intravenous)		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	SUBJECT TO OUT-OF-POCKET LIMIT?	SUBJECT TO LIFETIME MAXIMUM?	PROGRAM COVERS	
					IN-NETWORK	OUT-OF NETWORK
Emergency Room Treatment						
Initial care received within 72 hours after onset		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Care received more than 72 hours after onset or for follow-up services		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Cardiac Rehabilitation	Limited to 90 visits per calendar year	YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Hemodialysis treatment		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Intravenous therapy		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance
Other Hospital outpatient services		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
HOME HEALTH CARE						
Up to 90 home health care visits (up to 4 hours per visit) per "episode of care" A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance

Service	Special Limitations	Subject to Deductible?	Subject to Out-of-Pocket Limit?	Subject to Lifetime Maximum?	Program Covers	
					In-Network	Out-of Network
Home health care visits in excess of 90 per episode of care		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Physician visits		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
SKILLED NURSING FACILITY SERVICES						
Nursing Facility Services are counted toward the benefit limits applicable to inpatient hospital services. Each 2 days in a Skilled Nursing Facility count as one hospital inpatient day.	Coverage is subject to the same deductibles, coinsurance and benefit and lifetime limits that would have applied to the corresponding inpatient hospital day					
HOSPICE CARE SERVICES						
Services limited to maximum 180 day Hospice Eligibility Period Inpatient care limited to 60 days per Hospice Eligibility Period. Family counseling limited to $500 per Hospice Eligibility Period Bereavement services limited to $100 per Hospice Eligibility Period (covered only if provided within 90 days following the Member's death) Additional "reserve" benefits (up to 45 days) apply if the Member exceeds • The Hospice Eligibility Period and/or • The inpatient benefit limit		NO	NO	NO	100% of the Preferred Provider Allowance	100% of Program Allowance

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	SUBJECT TO OUT-OF-POCKET LIMIT?	SUBJECT TO LIFETIME MAXIMUM?	PROGRAM COVERS	
					IN-NETWORK	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES						
NOTICE: Except as noted below, coverage of Mental Health and Substance Abuse Services is subject to a Lifetime Maximum for Mental Health/Substance Abuse Care as described under "General Program Features". This Lifetime Maximum is in addition to the General Lifetime Maximum.						
Outpatient Services						
	Limited to 75 visits per calendar year	YES	NO	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Partial Hospitalization Services						
		NO	YES	YES	100% of the Preferred Provider Allowance	100% of Program Allowance
Inpatient Services						
Up to 60 days per confinement * A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days	Must be authorized in advance under utilization management program The Member's Preferred Provider will handle In-Network utilization management requirements on the Member's behalf	NO	NO	NO	100% of the Preferred Provider Allowance The Lifetime Maximum for Mental Health/Substance Abuse does not apply to this benefit	100% of Program Allowance The Lifetime Maximum for Mental Health/Substance Abuse does not apply to this benefit
Additional days in excess of 60 days per confinement		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
* The 60 day limit is reduced by Inpatient Hospital Services and Skilled Nursing Facility Services obtained by the Member during the same confinement.						

Service	Special Limitations	Subject to Deductible?	Subject to Out-of-Pocket Limit?	Subject to Lifetime Maximum?	Program Covers	
					In-Network	Out-of Network
Inpatient Physician and Health Care Practitioner Services and Consultations						
Visits by the attending physician	Covered only if hospitalization qualifies for coverage	YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
Inpatient Consultations	Covered only if hospitalization qualifies for coverage	YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance
MEDICAL DEVICES AND SUPPLIES						
		YES	YES	YES	80% of the Preferred Provider Allowance	80% of Program Allowance

Highlights of the Prescription Drug Program

Intelsat Services Corporation is pleased to offer you and your family access to a national network of pharmacies. Under the CareFirst PPO and Point-of-Service medical plan, you automatically receive prescription drug coverage. AdvancePCS administers the prescription drug benefit

If you have a question that is not covered in this handbook, call AdvancePCS at 800-241-3371.

- Your prescription drug program contains two components:
  - the Retail Card Program (used for obtaining prescriptions at local pharmacies), and
  - the Mail Service Program (used for obtaining maintenance drugs).
- You choose where your prescriptions are filled:
  - Participating (AdvancePCS) Pharmacy
  - Non-Participating (Non-AdvancePCS) Pharmacy
  - Mail-order service
- You choose the type of drug you want: generic or brand-name. You usually pay less out-of-pocket when you use generic drugs. See the Benefits Schedule for additional information.

How the Prescription Drug Program Works

When You Need a Prescription Filled

When you need prescription drugs you have the option of selecting how to purchase them based on your personal needs, the type of medication and the quantity needed.

Your coverage will depend on:

- whether you go to a Participating (AdvancePCS) Pharmacy, Non-Participating (Non-AdvancePCS) Pharmacy or obtain your drugs from the mail service
- the type of drug you purchase (generic or brand-name)

Generic vs. Brand-Name Drugs

The level of benefit you receive depends on whether you purchase generic drugs or brand-name drugs.

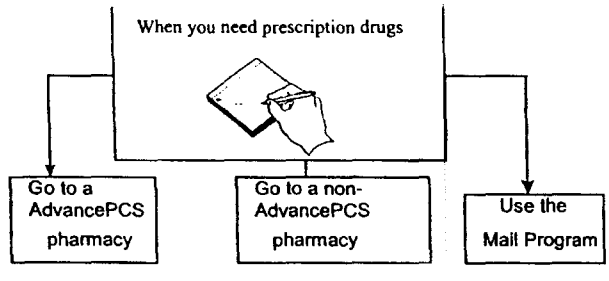
Generic drugs are drugs available from multiple manufacturers and by law must meet the same standards for safety and effectiveness as their brand-equivalent. Generic drugs are often less than half the cost of brand-name drugs.

Brand-name drugs are drugs available from a single manufacturer who has a patent for the product. They are generally more expensive than generic drugs. Brand-name drugs are sold and advertised by a single manufacturer under a specific trade name.

Using Participating (AdvancePCS) Pharmacies, Non-Participating (Non-AdvancePCS) Pharmacies, and the Mail Program

Each time you need to fill a prescription, you have the option of purchasing your drugs from:

- a Participating (AdvancePCS) Pharmacy,
- a Non-Participating (Non-AdvancePCS) Pharmacy, or
- the mail program



Using a Participating (AdvancePCS) Pharmacy

About 88% of the pharmacies in the Washington, DC, metro area participate in the AdvancePCS network. Refer to the list of chain pharmacies that was sent to you with your drug card to check if a specific chain pharmacy is part of the network. You may also call AdvancePCS Member Services at 800-241-3371 to locate a pharmacy in your area.

When you have a prescription filled, simply present your prescription drug identification card, along with your prescription to any Participating (AdvancePCS) Pharmacy. The pharmacist will fill the prescription and each family member must pay the first $50 in allowable charges during each calendar year. This is the prescription drug Deductible. After the Deductible is satisfied you will be charged a $5 Copayment per generic prescription. If a generic substitution is not available, you will be charged a $5 Copayment for each brand-name prescription.

If a generic substitution is available and you choose to use a brand-name drug, you will need to pay a $5 Copayment plus the difference in cost between the brand-name and generic drug. It will not be necessary for you to file any claim forms.

To be charged only your Copayment you must present your prescription identification card to the pharmacist.

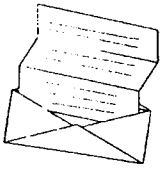
Using a Non-Participating (Non-AdvancePCS) Pharmacy

If you use a Non-Participating (Non-AdvancePCS) Pharmacy or you forget your ID card, you will need to pay the total charge of the prescription up-front and then file a claim for reimbursement. See the section entitled "Filing a Claim."

Please note that you will be reimbursed the discounted Program Allowance for a 34-day supply minus the appropriate retail Copayment for the generic or brand-name medication you purchased. This discounted Program Allowance may be less than you paid. If you choose to purchase more than a 34-day supply at one time, you will still only be reimbursed the Program Allowance for a 34-day supply. If the charges are over the discounted approved Program charge, you will not be reimbursed for the difference.

If a generic drug is available and you choose to use a brand-name drug, you will need to pay the $5 Copayment plus the difference in cost between the brand-name drug and the approved Program Allowance. If the charges are over the discounted approved Program Allowance, you will not be reimbursed for the difference.

Using the mail order program



You also have the option of filling prescriptions for maintenance drugs through the AdvancePCS Rx Services mail order program. A maintenance medication is a drug you may take on a regular long-term basis (such as medication to reduce blood pressure or high cholesterol). Through this service, you can obtain up to 90 days of a prescription at one time. If available, a generic drug will automatically be sent to you unless you or your physician specifies otherwise. You will have a $5 Copayment for generic drugs and a $10 Copayment for brand-name drugs, when no generic drug is available.

There may be times when you need a prescription for a maintenance drug filled immediately **but also know you will be taking it on an ongoing basis.** On this occasion, you should ask your doctor for two prescriptions: one for a 34-day supply that you can have filled immediately at a local pharmacy; and the other for up to a 90-day supply, plus refills, if appropriate, that you can send to AdvancePCS immediately. Refills for up to a one-year supply can be sent to AdvancePCS.

In most cases, your prescription will be sent to you through the U.S. Mail. Please allow 14 days from the time you put your prescription in the mail for your medication to arrive.

Filing a Claim

If you use your prescription drug card at a Participating (AdvancePCS) Pharmacy, you do not need to file a claim. Simply pay your Copayment, or extra charges if applicable, and the Program will take care of the rest.

Keep in mind that over 44,000 pharmacies are in the AdvancePCS network. However, if you need to use a pharmacy that is not part of the network — or you forget your identification card — you will need to pay up-front for your prescription and then file a claim for reimbursement. In this case, you will be reimbursed according to the discounted approved Program charge for the prescription. Claim forms are available from the Personnel Office at Intelsat Services Corporation, Inc.

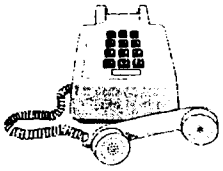
Retail Card Program: If you need to file a claim for prescriptions purchased at a non-AdvancePCS pharmacy or for prescriptions purchased without your ID card, send your claim to:

AdvancePCS
P.O. Box 85390
Richardson, TX 75085-3901

Mail Order Program: When submitting a mail order for maintenance prescription obtained through the mail service, send your prescription to:

AdvancePCS
P.O. Box 830070
Birmingham, AL 35282-8488

Member Services



Toll-free numbers are available for your inquiries. Your calls are handled by representatives who have been formally trained to answer your inquiries. Be sure to have your prescription ID card with you when inquiring about your coverage.

For questions regarding the Prescription Drug Program you may call the following toll-free numbers for assistance:

Retail Card Program: 800-241-3371
Monday through Friday, 8:30 a.m. to 12:00 midnight, and Saturday from 8:00 a.m. to 6:00 p.m., Eastern Standard Time. Emergency pharmacy consultation is available seven days a week, 24 hours a day.

Mail Order Program: 800-241-3371

Mail Order Program Number for the Hearing-Impaired: 800-863-5488

For Vision-Impaired Members: Upon special request with your mail order, the pharmacist will provide Braille labels for medication vials.

ATTACHMENT C
TO PROGRAM DESCRIPTION

SELF-INSURED PRESCRIPTION DRUG PROGRAM

CareFirst BlueCross BlueShield
550 12th Street, SW
Washington, DC 20065

This Attachment is made a part of the Program Description, Exhibit A to the Administrative Services Contract ("Contract") between the Group and CareFirst. The Contract, including this Attachment, sets forth and explains the duties and obligations of CareFirst and the Group and is the complete contract between CareFirst and the Group.

The Prescription Drug Program is included in the coverage of all Members. To qualify for these benefits, Eligible Employee/Members must enroll (or if Dependents, they must be enrolled) in the PPO Program Option or the Point-of-Service Program Option.

SECTION 1 DEFINITIONS

In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used:

1.1 Brand Pharmaceutical products for which there is a single innovator manufacturer or distributor source who has patent protection for the product.

1.2 Generic Pharmaceutical products for which patent protection has expired and which are available from multiple manufacturer or distributor sources in addition to the innovator source.

1.3 Pharmacy A licensed establishment where Prescription Drugs are dispensed by a pharmacist, including any pharmacy that operates under the licensure of a facility or institution of which it is an integral part even though the pharmacy itself is not a separately licensed establishment.

a. **Mail Service Pharmacy.** A Pharmacy that has an agreement in effect with CareFirst or its designee to provide mail service Prescription Drugs in accordance with the terms of this Attachment.

b. **Non-Participating Pharmacy.** A Pharmacy, other than a Participating Pharmacy or Mail Service Pharmacy, that regularly dispenses Prescription Drugs.

c. **Participating Pharmacy.** A Pharmacy, other than a Mail Service Pharmacy, that has an agreement in effect with CareFirst or its designee to provide Prescription Drugs in accordance with the terms of this Attachment.

1.4 Prescriber A doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine, a doctor of surgical chiropody, a doctor of podiatry, or a nurse practitioner, licensed as such by the duly constituted authority in the area in which the Prescription Order is issued and when acting within the scope of such licensure.

1.5 Prescription Drug A Federal legend drug, a State-restricted drug, or a compounded medication containing at least one Federal legend drug, dispensed pursuant to a Prescription Order for the outpatient or out-of-Hospital use of a Member covered under this Program. For the purposes of this Attachment, Prescription Drug also includes insulin, needles, syringes, and glucose testing strips subject to state dispensing laws.

1.6 Prescription Drug Program means the Self-Insured Program of benefits for prescription drugs and supplies as described in this Attachment.

1.7 Prescription Order The written or oral request for a Prescription Drug issued by a Prescriber duly licensed to make such a request in the ordinary course of his professional practice.

1.8 Program Allowance The reimbursement amount for Prescription Drugs as determined by CareFirst or its designee. The Program Allowance is accepted as payment in full by Participating Pharmacies and Mail Service Pharmacies, except for the copayment amounts, which are the Member's responsibility.

1.9 Schedule of Benefits means the table set forth in Section 2.4 in which benefit levels are summarized.

SECTION 2 PRESCRIPTION DRUG COVERAGE

2.1 Benefits will be available for Prescription Drugs dispensed by a Pharmacy for outpatient or out-of-Hospital use by a Member in accordance with the terms of this Attachment.

2.2 The payment of benefits will never be more than the amount that was actually charged for a Prescription Drug, and will fulfill CareFirst's or its designee's obligation under this Program.

2.3 Benefit payments will be based on Program Allowances for Prescription Drugs as determined by CareFirst or its designee. Copayments, as defined below, are the Member's responsibility. If the Program Allowance for Prescription Drugs is less than the applicable Copayment amount, the Member will pay the lower Program Allowance. Detailed information about the Copayment, including specific terms and amounts, can be found in the Schedule(s) of Benefits (section 2.4, below).

> **Copayment** - Benefits are based on a sharing of allowable charges between the Member and CareFirst or its designee. These costs are shared based on the allowable charges that CareFirst pays and the fixed dollar amount that the Member pays. This fixed dollar amount is referred to as the Copayment.

2.4 Schedule of Benefits

Participating Pharmacy	Members may use their prescription drug card to purchase a covered Prescription Drug from a Participating Pharmacy without submitting a claim. The Member is responsible for the Copayment.
Non-Participating Pharmacy	If the Member purchases a covered Prescription Drug from a Non-Participating Pharmacy, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee in the amount of the Program Allowance, minus the Copayment. NOTE: Members may be responsible for balances above the Program Allowance.
Mail Service Pharmacy	Members may submit a Prescription Order to a Mail Service Pharmacy and receive maintenance Prescription Drugs by mail. ("Maintenance Prescription Drugs" refer to those drugs taken on a continual basis typically for chronic conditions.) The Member is responsible for the Copayment. The Mail Service Pharmacy will not charge or collect payment from the Member for any amount which is in excess of the Copayment. Unless otherwise specified in the Prescription Order and in conformance with the laws governing Generic substitution, a Generic drug automatically will be dispensed in lieu of a Brand-name drug.
Plan Payment	100% of Program Allowance, minus the Copayment
Copayment for Prescription Drug Card	$5 Copayment per Generic Prescription Drug for up to a 34-day supply $10 Copayment per Brand Name Prescription Drug for up to a 34-day supply

Copayment for Mail Service Pharmacy	$5 Copayment per Generic Maintenance Drug for a 90-day supply $10 Copayment per Brand name Maintenance Drug for a 90-day supply
Supply Amount	A consecutive 34-day supply of a covered Prescription Drug unless limited by a lesser quantity designated by the Prescriber on the Prescription Order for Prescription Drug Card Services. A 90-day supply for Mail Service Pharmacy.
Refill Amount	Up to one year of Prescriber authorized refills
Oral Contraceptives	Covered
Smoking Deterrents	Covered

SECTION 3 LIMITATIONS

3.1 A Pharmacy may not dispense a Prescription Drug which in the pharmacist's professional judgment should not be dispensed.

3.2 Prescription Drugs will be dispensed according to the amount indicated in the Prescription Order, not to exceed the supply amount indicated in the Schedule(s) of Benefits.

3.3 Refills will be dispensed only pursuant to a Prescription Order and will be subject to the same limitations as contained in Paragraphs 1 and 2 above, and under any circumstances benefits for refills will not be provided beyond one year from the original Prescription Order date. In addition, refills will be limited to the refill amount indicated in the Schedule(s) of Benefits, and may be dispensed only when 75% of prescribed quantity has been consumed.

3.4 This Program carries no conversion privileges.

3.5 Certain Prescription Drugs may require prior authorization by CareFirst or its designee. Once the prior authorization request is approved, the Member may take advantage of electronic claims processing at Participating Pharmacies or have claims paid for drugs purchased from Non-Participating Pharmacies based on the Program Allowance, or have drugs dispensed by the Mail Service Program when applicable.

3.6 CareFirst reserves the right to limit coverage of Prescription Drugs to those drugs on the Program Drug Formulary which is a comprehensive, preferred medication list periodically reviewed and modified by CareFirst or its designee.

SECTION 4 EXCLUSIONS

4.1 In addition to the Exclusions contained in the Program Description to which this Attachment applies, no benefits will be provided for:

a. Any drug that is not a Prescription Drug as defined in Article I – Definitions, including but not limited to any drug that legally can be obtained by law without a Prescription Order, even if requested by a Prescription Order.

b. Therapeutic devices or appliances or other nonmedical substances, regardless of their intended use.

c. Administration or injection of any drug, including insulin.

d. Diaphragms, contraceptive jellies, creams, foams or devices.

e. Drugs used to treat obesity, assist weight reduction, or anorexiants.

f. Immunization agents, biological sera, blood or blood plasma.

g. Diabetic testing or monitoring devices.

h. Any drug for cosmetic purposes.

i. Rogaine.

j. Retin-A for a Member over age 34, except for use in treating acne vulgaris, keratosis follicularis, ichthyosis lamellar, or verruca plana.

k. Any quantity of drugs dispensed which exceeds the supply and refill amounts shown in the Schedule(s) of Benefits.

l. Any prescription refilled in excess of the number of refills specified in the Prescription Order; or any prescription or refill dispensed more than one year after the original Prescription Order.

m. Any drug that is dispensed to, administered to, or consumed by a Member in whole or in part, while he is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or other institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

n. Any drug that is consumed or administered at the place where it is dispensed or that is dispensed by a Prescriber.

o. Prescription Orders filled prior to the effective date or after the termination date of the coverage provided under this Program.

p. Drugs labeled "Caution -- Limited by Federal law to investigational use"; drugs that are experimental or investigational in nature, or that are in connection with experimental or investigative services or supplies, including drugs not in accordance with generally accepted standards of medical practice and drugs requiring federal or other governmental agency approval not granted at the time they are prescribed.

q. Injectable drugs except for insulin, Heparin, Glucagon, Imitrex (limit to 8 pre-filled syringes per month), EpiPen, AnaKit, and Depo-Provera or those covered under prior authorization.

r. RU-486.

SECTION 5 MISCELLANEOUS PROVISIONS

5.1 As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Pharmacy that furnishes Prescription Drugs hereunder to make available to CareFirst or its designee information relating to such benefits, copies of records thereof, and such other information and records as may be needed by CareFirst or its designee. CareFirst or its designee will in every case hold such information and records as confidential.

5.2 CareFirst or its designee will not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any Prescription Drug or any other item whether or not covered under this Program.

5.3 The Subscriber's current and applicable prescription drug card must be presented when a Member purchases Prescription Drugs at a Participating Pharmacy.

5.4 It is the Group's responsibility to notify Employee/Members of termination of coverage and to collect the prescription drug card from any Employee/Member whose coverage under this Program terminates for any reason.

a. Upon receipt of the prescription drug card from the Employee/Member, the Group will destroy such card.

b. The Group will be liable for any benefits provided on or after the termination date due to the Group's failure to notify employee of termination date or obtain such prescription drug card from the Employee/Member.

SECTION 6 GENERAL PROVISIONS

6.1 Terms and Conditions of the Contract. This Attachment is subject to all of the terms and conditions of the Program Description. This Attachment does not change any of those terms and conditions, except as specifically stated in this Attachment to the contrary.

6.2 Identification Card. Any cards CareFirst issues to a Member under the Prescription Drug Program are for identification only. Possession of an identification card confers no right to benefits under this Program. To be entitled to such benefits, the holder of the card must, in fact, be a Member of the Prescription Drug Program on whose behalf all applicable amounts under this Program have actually been paid. Any person receiving benefits to which he or she is not then entitled under the provisions of this Program will be liable for the actual cost of such benefits.

6.3 Relationship to Participating Pharmacies and Mail Order Pharmacies. Participating Pharmacies and Mail Order Pharmacies are independent contractors and are related to CareFirst by contract only. They are not employees nor agents of CareFirst and are not authorized to act on behalf of, or obligate CareFirst with regard to, interpretation of the terms of the Contract, this Attachment or the Prescription Drug Program, including eligibility of individuals for coverage or entitlement to benefits. Participating Pharmacies and Mail Order Pharmacies maintain a provider-patient relationship with the Member and they, not CareFirst, not the Group, and not the Plan Administrator, are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death, of providers, including Participating Pharmacies, Mail Order Pharmacies, or any other individual, facility or institution that provides services to Members or any employee, agent or representative of such providers. The ultimate decision whether to obtain care from a provider is made by the Member.